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* Mr. Justice Linden had just left the Commission at the time this working paper was approved, but he was involved in all the stages of its preparation. Judge Rivet was still a member of the Commission and Mr. Trevor-Deutsch was Project Co-ordinator. Madam Justice Picard and Professor Frémont joined the Commission after the document was approved.

Editor's Note

In keeping with the proposal advanced in *Equality for All: Report of the Parliamentary Committee on Equality Rights*, we have conscientiously endeavoured to draft this working paper in gender-neutral language. In doing so, we have adhered to the standards and policies set forth in *Toward Equality: The Response to the Report of the Parliamentary Committee on Equality Rights* pertaining to the drafting of laws, since the Commission's mandate is to make proposals for modernizing Canada's federal laws.

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Acknowledgements

The analysis in the following pages is based on information available in December 1990. However, the medical evaluation used as the starting-point for our study was completed in March 1990. Readers should bear these dates in mind.

We would like to thank the members of our Advisory Group of Experts on Health Law, which was officially consulted in November 1989. Needless to say, the views expressed in this paper do not necessarily reflect the positions of the group's individual members. The following individuals were consulted; they are listed in alphabetical order by field of expertise.

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Introduction

Technological development and the advancement of science, particularly medical science, constantly raise new challenges for our political and legal institutions. Social, moral, political and economic pressures force Parliament to systematically review the law and the practices arising therefrom. The law must take account of and promote scientific development, but must also impose the restrictions dictated by certain human and social values. Medically assisted procreation is perhaps one of the best examples of the challenges posed by the development of medical science and the tensions to which they give rise for the law.

National and world interest in medically assisted procreation reflects the importance ascribed to the risks, consequences and social and legal implications of the technologies being used. Whether the goal is to develop policies on reproductive technologies or reduce legal ambiguity,[1] society must reflect upon the choices to be made in view of existing conflicts and re-examine certain fundamental values and principles of law. Among issues of particular concern are the definition of the family; the filiation of children born as a result of medically assisted procreation; the commercialization of procreation, the human body and its products and substances; and the legal status of gametes and embryos. The potential and actual risks, both physical and psychological, raise concerns about public protection, including the protection of children born as a result of these technologies. We must therefore also consider the adequacy of the controls that apply to medically assisted procreation and the selection and storage of gametes and embryos.

However, developing a consistent national social policy on medically assisted procreation is not an easy task. The diametrically opposed views expressed in the reports of the Ontario Law Reform Commission[2] and the Barreau du Québec[3] on a number of fundamental aspects of the issue illustrate the problems. And the provisions in the Canadian Constitution on the distribution of powers between the federal government and the provinces do nothing to make matters easier.

The complexity and gravity of the issues raised by medically assisted procreation therefore demand careful consideration and serious discussion within Canadian society. It was

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1. Legal uncertainty can give rise to tremendous personal, family and social conflict. The American cases of *Baby M*, *infra*, note 302, *Davis* v. *Davis*, *infra*, note 203 and *York* v. *Jones Institute*, *infra*, note 204, as well as the *Rios* case involving orphaned embryos, *infra*, note 204, are good illustrations of this.

2. Ontario Law Reform Commission, *Report on Human Artificial Reproduction and Related Matters*, vols 1 and 2 (Toronto: Ministry of the Attorney General, 1985) [hereinafter OLRC].

3. Barreau du Québec, "Rapport du comité sur les nouvelles technologies de reproduction" (1988) 48:2 (Supp.) R. du B.

with this objective in mind that the federal government established the Royal Commission on New Reproductive Technologies.[4] The Commission was created for a specific purpose and is not intended to replace any permanent agency. Its mandate is to inquire into and report on current and foreseeable medical and scientific developments related to new reproductive technologies and their social, ethical, health, research, legal and economic implications. The Commission is also required to recommend policies and safeguards pertaining to a number of related issues.[5] It is to submit its report in October 1992.[6]

The Law Reform Commission of Canada undertook its examination of medically assisted procreation in an effort to advance the public debate and to complete its trilogy of studies in the area of medical law and procreation.[7] In May 1988, the task force set up by the Commission to review the status of the fetus recommended that the Commission inquire into the field of medically assisted procreation. In its working paper *Crimes against the Foetus* the Commission identified a number of issues that called for further research, among them surrogate motherhood, the need to establish national standards in view of the risk of interprovincial "procreative tourism" and to define the liability of donors who supply false information about their health status (genetic disorders, hereditary diseases, medical history) or who fail to provide pertinent information.[8] The Commission subsequently began a comprehensive study of the various technologies currently in use, and the phenomenon of surrogate motherhood.

The serious concerns that unsettle our society were also a factor in the Commission's decision to conduct this study. These concerns are often accompanied by demands for state

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4. P.C. 1989-2150, P.C. 1991-524. The Royal Commission was established under Part I of the *Inquiries Act*, R.S.C. 1985, c. I-11, which provides, *inter alia*, that commissioners are empowered to compel witnesses to appear (s. 4).

5. P.C. 1989-2150. The Commission's terms of reference include the following main issues:

   (a) implications of new reproductive technologies for women's reproductive health and well-being;

   (b) the causes, treatment and prevention of male and female infertility;

   (c) reversals of sterilization procedures, artificial insemination, in vitro fertilization, embryo transfers, prenatal screening and diagnostic techniques, genetic manipulation and therapeutic interventions to correct genetic anomalies, sex selection techniques, embryo experimentation and fetal tissue transplants;

   (d) social and legal arrangements, such as surrogate child-bearing, judicial interventions during gestation and birth, and "ownership" of ova, sperm, embryos and fetal tissue;

   (e) the status and rights of people using or contributing to reproductive services, such as access to procedures, "rights" to parenthood, informed consent, status of gamete donors and confidentiality, and the impact of these services on all concerned parties, particularly the children; and

   (f) the economic ramifications of these technologies, such as the commercial marketing of ova, sperm and embryos, the application of patent law, and the funding of research and procedures including infertility treatment.

6. P.C. 1991-524.

7. The first study dealt with criminal-law protection of the fetus: Law Reform Commission of Canada [hereinafter LRC], *Crimes against the Foetus*, Working Paper 58 (Ottawa: The Commission, 1989). The second dealt with biomedical experimentation on humans: LRC, *Biomedical Experimentation Involving Human Subjects*, Working Paper 61 (Ottawa: The Commission, 1989).

8. *Supra*, note 7 at 61. *Ibid.*: "Regulation of medical practice falls under provincial jurisdiction. In the absence of uniform, national accreditation procedures and limits of practice for institutions, the possibility of interprovincial 'procreative tourism' cannot be ignored and should be seriously examined."

intervention in the form of limits or controls justified by the scale of the costs involved, the need to impose limits on the development of medicine, the dangers of the marketing of procreation, the protection of the family unit and moral values, and the provision of safeguards against the exploitation of embryos, children, infertile couples and, especially, women.

Such demands are made by individuals and groups whose interests are sometimes at odds with the needs of those who are most directly involved (infertile or sterile individuals, physicians, scientists, and so on), and this can give rise to legal and social instability. In light of this instability and the inadequacy of other social controls,[9] legislative intervention may be needed to define and regulate the relationships between the parties and the social groups concerned and thus to restore social equilibrium. In this area, perhaps more than any other, we must be careful not to act too swiftly. The first step is to establish whether there is in fact a need for reform; only then can the scope of the change be determined.

Moreover, these social demands involve various aspects of the law which, needless to say, are of special interest to a law reform commission: law as an instrument of social change; law as a protector of the fundamental values of society; and law as a regulatory agent.

Our work centred around certain main themes. First, we examined the appropriateness of state intervention for purposes of limiting access to medically assisted procreation technologies or of controlling the use of such technologies. We considered the "problematic" medical aspects of the technologies and the ability of existing social and professional controls to provide adequate public protection (physical and psychological risks, selection, screening and storage standards, success rates, record keeping and access to medical and genetic information). We also looked at the need to review and, where necessary, adapt the law to the specific problems connected with the donation and deposit of gametes and embryos (ownership of genetic material and donor liability), and the filiation of the children involved. Finally, we examined the legal aspects of surrogate motherhood and the commercialization of procreation in general (sale of gametes and payments to surrogates).

Our study is divided into four chapters. The first two deal with the medical and legal aspects of the various technologies. The other two cover the role of the state and the reforms proposed by the Commission.

More specifically, chapter 1 explains the process involved in achieving pregnancy, the various kinds of infertility, and the technologies most often used to treat it. We will also discuss the genetic indications that may encourage the use of some of these technologies, and the risks and consequences associated with them. Particular attention will be paid to

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9. See chap. 3 regarding existing controls on medically assisted procreation. See chap. 2 regarding the shortcomings of positive law. See also Robert L. Kidder, *Connecting Law and Society: An Introduction to Research and Theory* (Englewood Cliffs, N.J.: Prentice-Hall, 1983), regarding the role of social forces.

success rates, the various ways of determining them and their effects on a couple's ability to choose the technology best suited to their situation. Finally, chapter 1 explains the various procedures used in gamete donation and the importance of donor selection.

Chapter 2 sets out the issues raised in Canadian law by the various situations made possible by the use of medically assisted procreation, in terms both of private law and of the rights protected by the *Canadian Charter of Rights and Freedoms*.[10] The main private law issues have to do with the legal status of gametes and embryos, the parentage of children born by means of new reproductive technologies, gamete donor liability, the liability of gamete and embryo banks and of physicians, the nature of surrogacy contracts, and the application of the principles of law with respect to the commercialization of the body, its products and substances. We will also study the influence of the *Charter* on state regulation of the use of medically assisted procreation technologies. In this connection, we will consider the question of the existence and limits of a possible constitutional right to procreate, and the influence of equality rights on the regulation of access to reproductive technologies. We will conclude with brief comments on the application of section 1 of the *Charter* in this context.

In order to determine the need for and the scope of possible state intervention in the area of medically assisted procreation, in chapter 3 we will deal with existing regulatory mechanisms, their scope and the role of the state.

In light of the analyses in the preceding chapters, chapter 4 will set out a series of proposals for reform designed to better define the interests at issue, to specify the rights and obligations of those involved in the use of reproductive technologies, and to create the necessary balance among the various values involved, such as respect for human dignity and respect for the individual rights and liberties of those concerned. We conclude our proposals with suggestions for putting in place a mechanism for implementing our recommendations.

Appendix A provides a description of the various measures recommended or adopted abroad — in particular Australia, the Council of Europe, Denmark, France, Germany, Norway, Spain, Switzerland, the United Kingdom, the United States — and, in Canada, at the federal level and in the common law provinces and in Quebec. Finally, appendix B provides a draft proposal indicating the structure that legislation governing the main aspects of medically assisted procreation might take.

We are aware that many of the questions raised in this study fall under provincial jurisdiction. But since they involve public health, the protection of certain fundamental values of our society, the protection of human life and bodily integrity, interprovincial and international trade, certain rights guaranteed by the *Canadian Charter of Rights and Freedoms*, and a clear need for uniformization, we believe that the federal government can and must play a major role as a catalyst in research and the development of a Canadian policy in the area of medically assisted procreation.

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10. Part I of the *Constitution Act, 1982*, being Schedule B of the *Canada Act 1982* (U.K.), 1982, c. 11.

CHAPTER ONE

Medical Aspects of Medically Assisted Procreation

About 15 percent of couples seek medical assistance concerning fertility problems.[11] Whether this is a reflection of an increasing incidence of infertility over the years is subject to debate. What is not in debate, however, is that the adoption of infants is becoming increasingly difficult and can no longer be considered the alternative to childlessness it once was.[12] As adoption has become more difficult, the use of reproductive technologies and the medical treatment of infertility have become more widespread. In this first chapter, we present an overview of infertility and the reproductive technologies most commonly used to overcome it. These include artificial insemination (AI), in vitro fertilization (IVF) and gamete intrafallopian tube transfer (GIFT).

It is clear that some procedures are of more therapeutic value than others. Because the ability of infertile couples to choose the option most suited to them may be impaired by confusing reports of success, success rates are discussed in detail. Also explained are the procedures of gamete (sperm and egg) donation, and the importance of preventing the transmission of serious infectious and genetic diseases through adequate donor screening.

I. Achieving Pregnancy

Males produce sperm continuously throughout their reproductive lives. An ejaculation often contains more than 100 million sperm per millilitre. This is in sharp contrast to the total of 400 to 500 eggs that will be ovulated, usually one at a time, once a month, from puberty to menopause in a woman's lifetime.

In the sexually mature woman, several immature eggs (oocytes) begin to develop each month in the ovaries. Usually only one reaches maturity. A structure called the follicle houses and nurtures the maturing egg until it reaches maturity under the cyclic influence of hormones released from the pituitary gland. During ovulation the mature egg is released from the follicle, complete with protective coverings. After ovulation the follicle continues to function, secreting hormones (progesterone and estrogen) that are necessary in preparing the uterine lining (the endometrium) for implantation.

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11. Canadian Fertility and Andrology Society, *Guidelines for Therapeutic Donor Insemination* (Montreal: The Society, 1988) at 8.

12. OLRC, *supra*, note 2 at 16, where the decrease in the number of newborns available for adoption in Ontario is discussed. In 1982, for example, 73 infants were placed for adoption, compared to 961 in 1969.

Pregnancy depends on a series of events that must be successfully synchronized. Sperm must be deposited into the vagina in adequate numbers and must have sufficient motility to travel from the vagina through the uterus and unobstructed fallopian tubes to meet the egg that has been released from the ovary.[13]

The egg is receptive to fertilization for approximately 24 hours, after which it dies. The average life span of sperm is 48 hours (although fertilization may occur up to three or more days after insemination).[14] Conception is therefore possible during only a few days of the menstrual cycle.

Fertilization begins with contact between a spermatozoon and the egg, and ends with the union of maternal and paternal chromosomes (the male and female pronuclei). This occurs in the upper third of the fallopian tube. The cell resulting from the union of male and female pronuclei is referred to as a zygote, pre-embryo, or conceptus, and its genetic material is already different from that of its biological parents.

Approximately 30 hours after fertilization, cell division occurs for the first time and continues while the pre-embryo or conceptus is still traversing the fallopian tube. At about three days following fertilization, when the conceptus is at the 16-cell stage, it enters the uterus. Implantation in the uterine wall occurs between the sixth and tenth day after fertilization. The conceptus is now a hollow ball of cells referred to as the "blastocyst."[15]

Relatively few concepti result in babies. It has been estimated that more than 60 percent are lost prior to 12 weeks' gestation, and 90 percent of these losses occur before the first missed menstrual period without the knowledge of the mother.[16] The clinical spontaneous abortion rate or rate of miscarriage is about 15 percent in the general population.[17] Approximately 50 to 60 percent of these miscarriages are due to chromosomal abnormalities, a result of imperfect gametes or abnormal fertilization. Thus, the number of spontaneous abortions is to a large extent a natural form of protection against the continuation of an abnormal pregnancy.[18]

Consequently, in any given cycle of 100 ovulatory women who actually conceive, only 25 will become aware of pregnancy; of these, approximately four will have a miscarriage and about 21 go on to produce a live baby. This is why humans are said to be inefficient procreators; and, as we shall see, the fact that they are constitutes one of the most intractable problems of medically assisted procreation.

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13. For a complete discussion see Keith L. Moore, *Before We Are Born: Basic Embryology and Birth Defects*, 3d ed. (Philadelphia: W.B. Saunders, 1989) chaps 2 and 3.

14. The process of swimming through the uterus and into the fallopian tubes induces a process called capacitation, which is the final step in the maturation of sperm. Capacitation is essential for successful fertilization.

15. Keith L. Moore, *The Developing Human: Clinically Oriented Embryology*, 4th ed. (Philadelphia: W.B. Saunders, 1988) at 27-35.

16. D. Keith Edmonds, Kevin S. Lindsay, John F. Miller *et al.*, "Early Embryonic Mortality in Women" (1982) 38:4 Fertil. Steril. 447.

17. *Ibid.* This figure varies according to age. For an explanation of spontaneous abortion, see *infra* at 14.

18. Moore, *supra*, note 15 at 34.

II. Infertility

Infertility is the involuntary, significant reduction of reproductive capacity. In North America, the generally recognized threshold of infertility is an inability to become pregnant after one year of unprotected intercourse.[19] The World Health Organization's standard is two years.[20]

Although Canadian studies of infertility prevalence are scarce, it has been reported that 15 percent of couples seek medical advice for infertility.[21] In the United States the prevalence of infertility has not changed significantly from 13.3 percent in 1965 to about 13.9 percent in 1982, excluding surgically induced sterility.[22]

Some of the factors influencing the prevalence of infertility are:[23] (1) trends toward childbearing later in life;[24] (2) environmental factors, such as infection from sexually transmitted diseases, and occupational exposure; (3) medical treatments such as those used for high blood pressure, stomach ulcer and cancer, as well as non-therapeutic drugs such as narcotics, alcohol and tobacco.[25]

A. Evaluation of the Infertile Couple

The infertile couple seeking medical help undergoes a series of procedures to determine the nature and severity of the problem. First a medical history is taken and, if necessary, counselling about timing effective intercourse is given.[26]

The woman is tested to detect hormonal dysfunction. There may be a biopsy of the uterine lining, and a hysterosalpingogram, which is an X-ray that reveals blockages of the fallopian tubes. Laparoscopy, which is the introduction of an endoscope into the abdomen, may be used to inspect the outer surfaces of the uterus, fallopian tubes and

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19. Mary G. Hammond, "Evaluation of the Infertile Couple" (1987) 14:4 Obstet. Gynecol. Clin. N. Am. 821.

20. M.A. Belsey and Helen Ware, "Epidemiological, Social and Psychosocial Aspects of Infertility" in Vaclav Insler and Bruno Lunenfeld, eds, *Infertility: Male and Female* (Edinburgh: Churchill Livingstone, 1986) 631 at 632.

21. Canadian Fertility and Andrology Society, *supra*, note 11 at 8.

22. Congress of the United States, Office of Technology Assessment [hereinafter OTA], *Infertility: Medical and Social Choices* (Washington, D.C.: OTA, 1988) at 51-52.

23. For a discussion of the prevention of infertility see Masood A. Khatamee, "Infertility: A Preventable Epidemic?" (1988) 33:4 Int. J. Fertil. 246. Also, for a discussion of factors influencing infertility see *Infertility: Medical and Social Choices*, *supra*, note 22 at 61-82.

24. For statistics on Canadian trends towards childbearing later in life see A. Romaniuc, *Fertility in Canada: From Baby-boom to Baby-burst* (Ottawa: Statistics Canada, 1984) at 27-32. Also, the prevalence of infertility has been found to be about 10 percent higher in women over 35: see *Infertility: Medical and Social Choices*, *supra*, note 22 at 52.

25. R.J. Sokel, Y. Liel and S.M. Glick, "Medical Conditions Leading to Infertility" in Insler and Lunenfeld, eds, *supra*, note 20, 673 at 677-81.

26. Hammond, *supra*, note 19 at 821-27.

surrounding structures for any abnormalities. These procedures are often painful, include slight risks of infection, and may result in the puncture of the uterus, although this last is rare. Medical precautions, such as the administration of antibiotics, are therefore taken to minimize risks.[27]

The man must undergo a semen analysis to evaluate the number and quality of sperm. If the semen is abnormal, blood tests may be performed to detect hormonal abnormalities.[28] A post-coital test may also be used to determine if there is incompatibility between the semen and female reproductive factors. This test requires the couple to have sexual intercourse timed to coincide with ovulation; within a few hours, post-coital tests of cervical mucus are performed.[29]

B. Causes of and Treatments for Infertility

Infertility may be traced to one partner, both partners, or to biochemical or immunological incompatibility between partners. Most female infertility is due to: ovulation disorders, usually because of hormonal abnormality; tubal blockage[30] as a result of infection and other disease processes; endometriosis;[31] and other causes, including abnormalities of the vagina or cervix, and mucous incompatibilities with sperm.[32]

Treatments for female infertility include hormone or drug therapy, surgery, and medically assisted procreation technologies such as IVF and GIFT.

Infertility due to an ovulation disorder is treated with ovulatory stimulants, which are very successful if infertility is due only to an ovulation disorder.[33] Other medical

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27. For further discussion see Leon Speroff, Robert H. Glass and Nathan G. Kase, *Clinical Gynecologic Endocrinology and Infertility*, 4th ed. (Baltimore: Williams & Wilkins, 1989) chap. 17.

28. Serial studies of fertile men have demonstrated great variability in sperm counts of individuals over time, emphasizing that at least two or three sperm counts are often necessary before an accurate count can be assigned. See Richard F. Spark, *The Infertile Male: The Clinician's Guide to Diagnosis and Treatment* (New York: Plenum, 1988) at 130. See also David W. Keller, Ronald C. Strickler and James C. Warren, *Clinical Infertility* (Norwalk, Conn.: Appleton-Century-Crofts, 1984) at 100.

29. Hammond, *supra*, note 19 at 826.

30. Peter McComb, Victor Gomel and Timothy Rowe, "Investigation of Tuboperitoneal Causes of Female Infertility" in Insler and Lunenfeld, eds, *supra*, note 20 at 213.

31. The tissue that lines the uterus, the endometrium, grows abnormally outside the uterus in endometriosis. Approximately 10 percent of pre-menopausal women have endometriosis and about 30 percent of affected women are infertile. Precisely how this form of infertility occurs is unknown. See Ken Muse, "Clinical Manifestations and Classification of Endometriosis" (1988) 31:4 Clin. Obstet. Gynecol. 813.

32. K.S. Moghissi, "Diagnosis and Classification of Disturbed Sperm-Cervical Mucus Interaction" in Insler and Lunenfeld, eds, *supra*, note 20 at 299.

33. Janet L. Kennedy and Eli Y. Adashi, "Ovulation Induction" (1987) 14:4 Obstet. Gynecol. Clin. N. Am. 821 at 838-44. See *infra* at 12 and note 55 for a discussion of the common risks. Risks for multiple pregnancy are reported to range between 6 and 12 percent with the use of clomiphene and between 4 and 18 percent

treatments include drugs to treat endometriosis, infection, and immune incompatibilities. For fallopian tube blockage, surgery may be used.[34] When other infertility treatments are unsuccessful, artificially assisted procreation may be employed, but as a last resort.

Male infertility typically results from decreased numbers or an absence of sperm in the semen, abnormal motility and structural abnormalities, all of which prevent normal fertilization of the egg. Precise causes of male infertility are often undetectable, but varicocele (varicose veins of the testes) or infection may play a role.[35] The absence of sperm (azoospermia) may be caused by impaired production of sperm or blockage of passageways. Although greatly reduced numbers of sperm (oligospermia) reduce fertility, there is still controversy as to the number of sperm necessary for normal reproductive functioning.[36]

When sperm counts fall below five million, fertility is significantly reduced.[37] Therefore, couples unwilling to wait the several years often necessary to achieve "natural" pregnancy may seek treatment for male factor infertility. These treatments include hormonal therapy and such laboratory techniques as the "swim-up"[38] procedure that aim to improve the concentration of normal sperm available for fertilization. However, the success of these procedures in conjunction with the use of artificial insemination is less than 20 percent.[39]

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with the use of menotropin (Pergonal®). The risk of provoking "hyperstimulation syndrome" is greater with the use of Pergonal® than with clomiphene. It is a syndrome of varying severity, where a mildly affected woman (15 percent) will suffer enlarged ovaries and a severely affected woman (one percent) will suffer fluid shifts in the body which may be severe enough to cause shock. Her ovaries may enlarge to the extent that rupture is a possibility, requiring removal of the ovaries and, very rarely, death has been reported. Therefore close medical observation is required with the use of some ovulatory stimulants. See also Richard Borenstein *et al.*, "Severe Ovarian Hyperstimulation Syndrome: A Reevaluated Therapeutic Approach" (1989) 51:5 Fertil. Steril. 791.

34. See, for a review of indications, success and cost analysis, Ricardo Marana and John Quagliarello, "Distal Tubal Occlusion: Microsurgery versus In Vitro Fertilization — A Review" (1988) 33:2 Int. J. Fertil. 107. By the same authors see also "Proximal Tubal Occlusion: Microsurgery Versus IVF — A Review" (1988) 33:5 Int. J. Fertil. 338 at 338-40.

35. Spark, *supra*, note 28 at 129-33.

36. *Ibid.* Although a sperm count less than 10 million is considered unacceptably low, some pregnancies have occurred in partners of men with sperm counts below 5 million (*ibid.* at 129).

37. Erik Bostofte, Jorgen Serup and Heinrich Rebbe, "Hammen Semen Quality Classification and Pregnancies Obtained during a Twenty-Year Follow-up Period" (1981) 36:1 Fertil. Steril. 84.

38. The purpose of the "swim-up" procedure is to obtain the highest concentration of motile sperm possible by collecting sperm that have been placed in a container and have swum to the top of a special medium. Nancy J. Alexander and Steven Ackerman, "Therapeutic Insemination" (1987) 14:4 Obstet. Gynecol. Clin. N. Am. 905 at 909.

39. *Ibid.* at 911. A compilation of the literature reporting 812 cases of male factor infertility treated by means of AIH sperm yielded a pregnancy rate of 18 percent.

In theory, one might expect that IVF could be useful in the treatment of male factor infertility. Once the egg is placed directly in a container with the partner's sperm, the normal sperm, even if there are relatively few, should be able to fertilize the egg. This would provide the couple with a child genetically related to both parents. But the ability of the sperm to fertilize the egg appears to be only half as successful as in cases of IVF with non-male factors.[40] Nevertheless, there are reports that find IVF for male factor infertility as successful as IVF for other reasons.[41] In any event, artificial insemination by donor (AID) is considered a leading remedy for both the infertile and sterile male because it is less costly, less invasive, and statistically much more successful than IVF.[42]

III. Genetic Indications for Medically Assisted Procreation

Individuals who are not infertile but risk transmitting serious genetic diseases[43] or abnormalities may be considered "reproductively disabled" and are therefore candidates for medically assisted procreation. These individuals may require a donation of one or both gametes if the disease the gene of which they carry is not detectable through prenatal diagnostic techniques or if the couple is not amenable to the therapeutic abortion of an affected fetus. There are three types of transmissible genetic disease: an autosomal recessive disease such as Tay-Sachs disease or thallasemia;[44] an X-linked disease such as Duchenne muscular dystrophy or hemophilia;[45] or an autosomal dominant disorder such as Huntington's disease.[46] The presence of chromosomal (structural or numerical) abnormalities may also present significant risks for the offspring.

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40. *Ibid.* at 913. See also A. Acosta *et al.*, "The Role of In Vitro Fertilization in Male Infertility" (1988) 541 Ann. N.Y. Acad. Sci. 297 at 301; and Irvin Hirsch *et al.*, "In Vitro Fertilization in Couples with Male Factor Infertility" (1986) 45:5 Fertil. Steril. 659 at 662.

41. In selected populations of male factor infertility, IVF success is comparable to other indication for IVF. See Hirsch *et al.*, *supra*, note 40 at 663.

42. Alexander and Ackerman, *supra*, note 38 at 918ff.

43. Individually, genetic diseases are usually very rare, but when all genetic diseases are considered together, they account for more than 30% of all pediatric hospital admissions. Judith G. Hall, "Impact of Genetic Disease on Pediatric Health Care" in M.M. Kaback and L.J. Shapiro, eds, *Frontiers in Genetic Medicine: Report on the 92nd Ross Conference on Pediatric Research* (Columbus, Ohio: Ross Laboratories, 1987) 1 at 1.

44. Only when both partners carry the gene for an autosomal recessive disease is the offspring at risk. The disease occurs only if the offspring inherits both disease genes, one from each parent. The risk for disease occurrence is 25 percent for each pregnancy.

45. Also referred to as a sex-linked disease, the disease gene is located on the X chromosome and is most often passed on from an unaffected mother (who has two X chromosomes) to her son (who has one X chromosome along with a Y chromosome). Each son has a 50 percent chance of inheriting the disease, and each daughter has a 50 percent chance of inheriting the disease gene and becoming a carrier, usually without being affected herself.

46. If either parent carries the disease gene, each child will have a 50 percent chance of inheriting the disease.

IV. Medically Assisted Procreation Technologies

A. In Vitro Fertilization (IVF)

In 1878 the first attempts at in vitro fertilization were made using rabbits and guinea pigs. One hundred years after these first animal experiments, the first test-tube baby was born.[47] Since that time more than 3,000 children have been born worldwide as a result of IVF.[48] It is most commonly used when infertility is caused by blocked fallopian tubes, but is also used in some cases of endometriosis, and in male factor and unexplained infertility.[49]

By definition, in vitro fertilization implies the fertilization of an egg outside the future mother's body, or "in glass." The procedure is accomplished by removal of mature eggs from the ovary, fertilization in a container, and transfer of the early-developing concepti back into the uterus.

The IVF procedure involves five steps: (1) administration of superovulation drugs; (2) removal of one or more mature eggs from the ovary; (3) fertilization of one or more of these eggs outside the body; (4) incubation of the fertilized egg(s) until they are ready for transfer; and (5) transfer of early-developing concepti into the uterus.[50] The success of each step is contingent on the preceding one. Failure at any stage results in failure to become pregnant.

1. Superovulation

The probability of achieving pregnancy, and eventually live birth, increases when three or four embryos are simultaneously implanted in the uterus. Therefore, virtually all IVF programs throughout the world use drugs, individually or in combination, that induce the maturation and ovulation of more than one egg per cycle.[51]

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47. S. Fishel, "IVF — Historical Perspective" in S. Fishel and E.M. Symonds, eds, *In Vitro Fertilisation: Past, Present, Future* (Oxford: IRL Press, 1986) 1 at 1-16.

48. Machelle M. Seibel, "A New Era in Reproductive Technology" (1988) 318:13 New Engl. J. Med. 828.

49. *Ibid.* at 828-29.

50. The Reproductive Endocrinology and Fertility Committee, Society of Obstetricians and Gynaecologists of Canada, "In Vitro Fertilization and Embryo Transfer in Canada" (1987) 9:3 SOGC Bulletin 15 at 16-17 [hereinafter *IVF-ET Canada*].

51. The most common drugs used are clomiphene citrate (Clomid®), menotropins (Pergonal®), and human chorionic gonadotropins (HCG). *IVF-ET Canada*, *supra*, note 50 at 16. Gary D. Hodgen, "Physiology of Follicular Maturation" in Howard W. Jones, Jr., *In Vitro Fertilization — Norfolk* (Baltimore: Williams & Wilkins, 1986) 8 at 9. See also I.T. Cameron and D.L. Healy, "Patient Management" in Carl Wood and Alan Trounson, eds, *Clinical In Vitro Fertilization*, 2d ed. (London: Springer-Verlag, 1989) 11 at 15. For the risks involved with the use of these drugs, see *supra*, note 33.

Ovulation induction is successful approximately 80 percent of the time (an unsuccessful stimulation is referred to as a "cancelled cycle").[52] During treatment, patients are either admitted to hospital or outpatient facilities so that frequent blood samples can be taken to evaluate hormone levels and ultrasound monitoring of developing follicles may be carried out.[53]

Common side-effects of superovulation drugs include: hot flushes (10 percent), abdominal distention and pain (5.5 percent), breast discomfort (2 percent), visual disturbances (1.5 percent), headache (1.3 percent) and loss of hair (0.3 percent).[54] The "hyperstimulation syndrome" occurs rarely in IVF trials. The occurrence of this syndrome is minimized by medical precautions including the emptying of all the follicles, frequent ultrasound evaluations of ovaries and the control of blood hormonal levels.[55]

2. Egg Retrieval

Egg retrieval is performed with the aid of laparoscopy or ultrasound. In laparoscopy, the abdominal wall is punctured and the abdomen inflated with a gas mixture. This creates a space between the abdominal wall and the intra-abdominal organs. One or more tubes, including an endoscope, are then inserted into the space so that the surgeon can observe and manipulate the ovaries without having to make too large an incision. The mature eggs are then removed from the follicles. The main disadvantage of laparoscopy is that a general anesthetic is required, in addition to the use of several drugs during and after the laparoscopy to maintain the effect of the anesthetic and relieve pain. There has been concern regarding the effects of these drugs on the pregnancy, since it is known that they may enter the follicular fluid. Studies thus far, however, show no apparent effect on the outcome of the pregnancy.[56]

Ultrasound-guided retrieval of ova is often preferable to laparoscopic techniques because it is less invasive, and because a general anesthetic is not necessary.[57] Ultrasound employs high-energy sound waves, beamed from outside the body, to create images of internal organs and structures.[58] The surgeon uses the ultrasonic image of the ovary to guide a needle into the follicles through either the vagina, the urethra, or the abdominal wall.[59] Mature ova are then aspirated out of the ovary.

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52. Cameron and Healy, *supra*, note 51 at 15.

53. G.T. Kovacs, "Selection and Preparation of Patients for In Vitro Fertilization" in Wood and Trounson, eds, *supra*, note 51, 1 at 2.

54. Kennedy and Adashi, *supra*, note 33 at 838. See also Speroff, Glass and Kase, *supra*, note 27 at 591.

55. Daniel Navot *et al.*, "Risk Factors and Prognostic Variables in the Ovarian Hyperstimulation Syndrome" (1988) 159:1 Am. J. Obstet. Gynecol. 210 at 214. See also Cameron and Healy, *supra*, note 51 at 15. For a description of the syndrome, see *supra*, note 33.

56. J. Webster, "Laparoscopic Oocyte Recovery" in Fishel and Symonds, eds, *supra*, note 47 at 69. See also J. Leeton, "Oocyte Pick-up" in Wood and Trounson, eds, *supra*, note 51, 23 at 24.

57. Leeton, *supra*, note 56 at 24.

58. Lucy Frank Squire and Robert A. Novelline, *Fundamentals of Radiology*, 4th ed. (Cambridge: Harvard University Press, 1988) at 27.

59. Procedures that involve puncture of a full bladder to reach the ovary create the most discomfort, and limited relief is achieved from the use of a local anesthetic. Leeton, *supra*, note 56 at 25.

In terms of numbers and quality of recovered eggs, the laparoscopy and ultrasound methods are comparable. On average, four eggs are retrieved per cycle, but as many as 20 may be produced.[60]

Medical risks of egg retrieval include those inherent in the administration of a general anesthetic, if used. Also, there are risks of vaginal bleeding, pain, pelvic infection,[61] and the inadvertent puncture of blood vessels. There has been at least one death resulting from undetected bleeding following an egg-retrieval procedure.[62]

3. Evaluation of Eggs, Fertilization and Embryo Transfer

Recovered eggs are examined under the microscope for quality and maturity, so as to increase the likelihood of normal fertilization. A similar evaluation and preparation will already have been carried out on the sperm sample. The sperm is then added to a dish or test-tube containing the egg.[63]

If fertilization is successful, concepti are incubated. This induces cell division to the four-cell stage within approximately 44 hours. The concepti are transferred into the uterus at between the four- and eight-cell stage of development, after which the woman is discharged from the hospital and is usually encouraged to resume normal activity.[64]

4. IVF Success Rates

The difficulty in assessing the success of in vitro fertilization is that one clinic's criteria may not be comparable to another's. Criteria of success include the number of "chemical," "clinical," or "viable" pregnancies. These may be calculated on the basis of "treatment cycles," "egg retrievals," "embryo transfers" or number of women treated. The many combinations of "success" criteria can be confusing. To dispel the confusion, the definitions of each possible "numerator" and "denominator" should be understood.[65]

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60. P. Dellenbach *et al.*, "The Transvaginal Method for Oocyte Retrieval" (1988) 541 Ann. N.Y. Acad. Sci. 111.

61. The risk for pelvic infection, which may be severe, is reported to be about 3 percent and is reduced with the administration of antibiotics. See Robert S. Howe et al., "Pelvic Infection after Transvaginal Ultrasound-Guided Ovum Retrieval" (1988) 49:4 Fertil. Steril. 726 at 728.

62. Seibel, *supra*, note 48 at 829-30.

63. The concentration of sperm added to the egg(s) is much greater than that which would normally meet the egg in the fallopian tubes. See A. Trounson, "Fertilization and Embryo Culture" in Wood and Trounson, eds, *supra*, note 51, 33 at 33-47.

64. Seibel, *supra*, note 48 at 830-31. See also *IVF-ET Canada*, *supra*, note 50 at 17.

65. Hillary Page, "Calculating the Effectiveness of In-Vitro Fertilization: A Review" (1989) 96:3 Br. J. Obstet. Gynaecol. 334; A. Albert Yuzpe *et al.*, "Rates and Outcome of Pregnancies Achieved in the First 4 Years of an In-Vitro Fertilization Program" (1989) 140:2 C.M.A.J. 167 at 168.

5. Numerator Determination

A "chemical pregnancy," or preclinical miscarriage, is a pregnancy that is detectable by biochemical means (HCG determinations) but does not persist long enough to delay menstruation beyond 14 days. The pregnancy is not detectable clinically, no identifiable tissue is passed, and no medical action is necessary.[66]

A clinical pregnancy is a pregnancy detectable both by biochemical means and ultrasound, maintained until at least 28 days after egg retrieval.[67] These criteria would indicate that the conceptus has implanted and may be considered analogous to pregnancy by natural means. A pregnancy is considered "clinical" until the point of viability. If a clinical pregnancy is lost, it is considered a spontaneous abortion or miscarriage. Medical action may be required.

Finally, although the definition of viability may differ from jurisdiction to jurisdiction, a pregnancy is generally considered to be "viable" beginning 22 weeks after the last menstrual period.[68] The fetus is then considered capable of independent existence outside the mother's body.

The number of live births is probably the most important criterion of success, and certainly the numerator in which most couples treated are interested. It should be noted, however, that even this "bottom-line" figure can be confusing if the rate of multiple pregnancy is not clearly reported. For example, 100 live births does not necessarily mean that 100 couples will take home one baby each, since a substantial number of these live births will be births of twins, triplets, and so on. Therefore, some authors feel that reporting the proportion of deliveries relative to attempts would be the least confusing reflection of success because the chances of taking home at least one baby could be determined.

6. Denominator Determination

Couples must be made clearly aware of the variations and limits of reporting methods, so they can exercise fully informed consent to IVF.[69] For example, an IVF clinic may indicate that it has achieved a 20-percent pregnancy success rate.[70] As explained above, couples should first be informed what the denominator is: the hormonal treatment cycle? egg retrieval procedure? or embryo transfer (ET) procedure? Second, couples should be aware that a 20-percent pregnancy success rate per embryo transfer still does not necessarily reveal all the statistical and psychological realities of the process.

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66. Page, *supra*, note 65 at 334.

67. *Ibid.*

68. *Crimes against the Foetus*, *supra*, note 7 at 43 n. 93.

69. Fiona J. Stanley, "In-Vitro Fertilization — A Gift for the Infertile or a Cycle of Despair?" (1988) 148 Med. J. Australia 425.

70. See Kate Dunn, "Today — Cloned Cows. Tomorrow — You?" *The [Montreal] Gazette* (8 July 1989) A-1 at A-4.

Let us assume, for instance, that 200 couples enter an IVF clinic that claims a success rate of 20 percent per embryo transfer. Couples might reasonably conclude that 40 of the women are likely to become pregnant. In fact, many fewer are likely to do so because many couples will not reach the embryo transfer stage. At step one of the IVF process, the treatment cycle, some 40 of the original 200 couples will leave the program because, in general, 20 percent of IVF hormonal treatment cycles are unsuccessful.[71] Of the remaining 160 couples, another 24 (15 percent) will likely drop out prior to embryo transfer owing to difficulties at the egg retrieval and fertilization stages.[72]

This brings about 136 of the original 200 couples to the embryo transfer stage. Applying the clinic's stated 20-percent pregnancy rate per embryo transfer means that about 27 of the original 200 women will become pregnant, not 40 as one might reasonably expect. Statistically this translates into only a 13-percent pregnancy rate per treatment cycle (if this is the denominator chosen). Clearly, a "success rate of 20 percent," taken in isolation, is meaningless. The numerator and denominator must be known and must be the same in order for clinics to be compared with each other. Standardized methods of reporting success rates would greatly enhance couples' ability to make informed choices.

7. International Results

Table 1 (see *infra* at 35) gives recent statistics of national registries from Australia[73] (13 centres), the United States[74] (96 centres), and the United Kingdom[75] (42 centres). Because different reporting methods are used, it is difficult to establish a common criterion of "success." However, a crude measure of delivery rate (clinical pregnancies minus miscarriages and ectopic pregnancies) per hormonal treatment cycle may be instructive. Current data yield success rates of between six and nine percent. However, this is an over-estimation of the "take-home baby" rate because stillbirths and early deaths of newborns are not considered.

Further, there is great variation in reporting methods among clinics. For example, in the United Kingdom, the Interim Licensing Authority (ILA) (formerly called Voluntary Licensing Authority) classifies data according to whether the centre is small, medium or large. The six large centres average a clinical pregnancy rate of 14.3, and 10 small centres

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71. See *supra*, note 52 and accompanying text.

72. Between 10 and 20 percent of patients who undergo egg retrieval do not reach the embryo transfer stage of IVF. H.W. Jones, Jr., and P.A.W. Rogers, "Results from In Vitro Fertilization" in Wood and Trounson, eds, *supra*, note 51, 51 at 57.

73. Australian In-Vitro Fertilization Collaborative Group, "In Vitro Fertilization Pregnancies in Australia and New Zealand, 1979-1985" (1988) 148 Med. J. Australia 429 [hereinafter *Australia IVF*]. See also Stanley, *supra*, note 69 at 425.

74. Medical Research International and the Society of Assisted Reproductive Technology, The American Fertility Society, "In Vitro Fertilization/Embryo Transfer in the United States: 1987 Results from the National IVF/ET Registry" (1989) 51:1 Fertil. Steril. 13 [hereinafter *U.S. IVF/ET 1989*].

75. *The Fifth Report of the Interim Licensing Authority for Human In Vitro Fertilisation and Embryology 1990* (London: ILA, 1990) at 35-37 [hereinafter ILA].

average 9.2 percent.[76] In France there is also a disparity among clinics. As of April 1987, 17,000 oocyte recoveries were reported nationwide, resulting in 1,340 deliveries (7.8 percent). Although the number of pregnancies per embryo transfer generally was 14 percent, some clinics reported rates as high as 35 percent.[77] Individually published reports offer better success rates than those using compiled data.[78]

8. Canadian Results

IVF/ET programs have been in operation in Canada since 1982; currently there are 13 active programs. A recent report evaluating data from 11 Canadian centres between 1982 and 1988 showed that of 5,921 treatment cycles begun for 3,277 couples, a total of 460 live children were delivered. This translates into a rate of 7.9 percent live births per treatment cycle and 14.3 percent per couple treated.[79] Since multiple pregnancy rates were not reported, exact delivery rates cannot be calculated. Assuming, however, rates similar to those in other reports in the literature, it can be presumed that the take-home baby rate was about 20 percent less than stated success rates.

Reports from individual clinics in Canada are scarce.[80] One recent report from the University Hospital and the University of Western Ontario[81] summarized rates and outcomes of pregnancies from February 1, 1984 to December 31, 1987 at that centre. A clinical pregnancy rate of 12.3 percent per treatment cycle with a take-home baby rate per treatment cycle of 6.4 percent was reported.[82] The authors consider this to be an underestimation of current success rates, given recent improvements in technology.

A confidential voluntary national registry of pregnancies achieved by IVF or GIFT was begun at the Toronto East General Hospital in 1987.[83] This registry is incomplete because several centres have not submitted results.[84] More recently, the Ontario Medical Association has proposed guidelines (the first in Canada) to ensure the quality of IVF

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76. *Ibid.* at 20.

77. ESHRE (European Society of Human Reproduction and Embryology), Conference, October 1987, discussion, Michelle Plachot, J.P. Renard, Nicole Questiaux, J. Testart, speakers; R.G. Edwards, chair, "Discussion on Ethical and Judicial Aspects of Embryo Research" (1989) 4:2 Human Reprod. 206.

78. René Frydman *et al.*, "An Obstetric Assessment of the First 100 Births from the In Vitro Fertilization Program at Clamart, France" (1986) 154:3 Am. J. Obstet. Gynecol. 550; Geoffrey Sher *et al.*, "In Vitro Fertilization and Embryo Transfer: Two-Year Experience" (1986) 67:3 Obstet. Gynecol. 309.

79. See Stanley E. Brown, "In Vitro Fertilization — The Canadian Experience" (1989) 11:3 J. SOGC 27 at 28 and 31.

80. See *IVF-ET Canada*, *supra*, note 50 at 15. Two from among the few reports are Patrick J. Taylor *et al.*, "Initial Experience with In Vitro and Embryo Transfer at the University of Calgary/Foothills Hospital" (1985) 2:2 J. In Vitro Fert. Embryo Transfer 112; and Jacques-E. Rioux *et al.*, "Center for In Vitro Fertilization, Québec, Canada" (1984) 1:1 J. In Vitro Fert. Embryo Transfer 89.

81. Yuzpe *et al.*, *supra*, note 65 at 167.

82. *Ibid.* at 169-70. The rate of 6.4 percent was established on the basis of delivery and stillbirth rates.

83. See Note, "Canadian IVF Register" (1987) 9:3 SOGC Bulletin 19.

84. Personal communication, J. Tolentino and P. Phillips at the LIFE Program, Toronto.

services, including recommendations that a provincial registry be established and operated by the Ministry of Health. The registry would include details of parentage, success or failure rates, and pregnancy outcome. The guidelines recommend that this registry be confidential and available for peer review.[85]

9. Other Outcomes of IVF

Although the birth of a child is the first goal, IVF may have other outcomes: spontaneous abortion,[86] perinatal mortality and morbidity,[87] multiple[88] and ectopic[89] pregnancies, and Cesarean sections.[90] Rates for all of these are substantially higher in IVF pregnancies than in the general population.

(a) Multiple Pregnancies and Perinatal Risks

One in four women who have had successful IVF or GIFT treatment is delivered of twins or higher-order multiple births.[91] This is a much higher rate than is seen in the

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85. Ontario Medical Association, "OMA Guidelines for In Vitro Fertilization Programs in Ontario" (1990) 57:12 Ontario Med. Rev. 28.

86. According to the report, miscarriage rates are approximately 25 percent compared to 15 percent for the general population. See table 1, *infra* at 35.

87. Perinatal mortality is defined as the number of fetal deaths (stillbirths) and neonatal (newborn) deaths, from viability until 28 days after birth. Judith S. Mausner and Shira Kramer, *Epidemiology — An Introductory Text*, 2d ed. (Philadelphia: W.B. Saunders, 1985) at 92-93, 104-06. Perinatal morbidity refers to illnesses or defects of live-born infants during the same time span. See discussion in text at note 93, *infra*.

88. J. Cohen, M.J. Mayaux and M.L. Guihard-Moscato, "Pregnancy Outcomes after *In Vitro* Fertilization: A Collaborative Study of 2342 Pregnancies" (1988) 541 Ann. N.Y. Acad. Sci. 1 at 5. See also ILA, *supra*, note 75 at 19. The multiple pregnancy rate is about 20 percent compared to about one percent in the general population (rates of multiple pregnancies in the general population vary with race, age, and number of previous pregnancies). For a discussion of the epidemiology of multiple births see Jack A. Pritchard, Paul C. MacDonald and Norman F. Gant, *Williams Obstetrics*, 17th ed. (Norwalk, Conn.: Appleton-Century-Crofts, 1985) at 503.

89. An ectopic pregnancy is a pregnancy that occurs outside the uterus, usually in the fallopian tube, and is usually caused by a blockage of the fallopian tube that prevents the concepti from entering the uterus. The pregnancy in the fallopian tube may lead to a potentially life-threatening emergency that requires surgical removal of the affected tube. The ectopic pregnancy rate for IVF ranges between 4.5 and 7.5 percent compared to 1.5 percent in the general population. See table 1, *infra* at 35 for international rates.

90. Cohen, Mayaux and Guihard-Moscato, *supra*, note 88 at 3; and Yuzpe *et al.*, *supra*, note 65 at 170. Cesarean section rates are 47 and 72 percent for single and multiple pregnancies respectively, compared to general population statistics of 15 and 44 percent.

91. An international analysis of results of IVF and GIFT demonstrates a rate of multiple pregnancy of approximately 24 percent. See tables 1 and 2, *infra* at 35, 36. These figures represent national averages. It is well known, however, that individual unit rates will vary. For example, Yuzpe *et al.*, *supra*, note 65, report a multiple pregnancy rate of 16 percent and Frydman *et al.*, *supra*, note 78 at 552 and 554 report a multiple pregnancy rate of 12 percent.

general population, where the rate ranges between 1 in 80 to 95 births, although this is difficult to define precisely in the general population.[92]

A recent report from Australia concludes that pregnancies conceived through IVF and GIFT should be considered high-risk procedures because the perinatal mortality rate is three times that of the general population, and there is a high percentage of low-birth-weight infants. There are several contributing factors, such as the age of the mother and the infertility treatment itself. That said, 50 percent of the premature births and 70 percent of the low-birth-weight infants were associated with multiple pregnancies.[93] Of 460 live births resulting from IVF in Canada between 1982 and 1987, 21 died soon after birth (neonatal death). The majority of these were a result of premature birth, often associated with multiple pregnancies.[94]

Perinatal mortality is consistently higher in twins than in singleton (single baby) deliveries. In North America there are 14 to 16 deaths per 1,000 births for singletons. But for twins, perinatal mortality is reported to be four to seven times higher.[95] Thus, twin pregnancies, which represent only one percent of all births, account for 10 percent of all premature deliveries and 25 percent of pre-term deaths.[96] Associated with prematurity are breathing difficulties,[97] a predisposition to hemorrhages in and around the brain[98] and infection.[99]

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92. The actual rate of multiple pregnancies can be difficult to define because reporting methods vary internationally. See B.J. Botting, I. MacDonald Davies and A.J. MacFarlane, "Recent Trends in the Incidence of Multiple Birth and Associated Mortality" (1987) 62 Arch. Dis. Child 941 at 942. Further complicating the analysis of the number of fetuses per *pregnancy* is the "vanishing twin" phenomenon, which describes the spontaneous reduction rate of twin pregnancies resulting in the loss of at least one of the fetuses. Early pregnancy ultrasound studies have demonstrated spontaneous reduction in fetuses to be similar to or higher than the spontaneous abortion rate in singleton pregnancies. Therefore, if IVF units report multiple pregnancy rates detected early in pregnancy, the rates will be greater than those reported at delivery time. See the discussion in Katharine D. Wenstrom and Stanley A. Gall, "Incidence, Morbidity and Mortality, and Diagnosis of Twin Gestations" (1988) 15:1 Clinics Perinatol. 1 at 2.

93. Douglas M. Saunders and Paul Lancaster, "The Wider Perinatal Significance of the Australian In Vitro Fertilization Data Collection Program" (1989) 6:2 Am. J. Perinatol. 252 at 252-53. See also *Australia IVF*, *supra*, note 73 at 433. Of 1138 live-born infants, 438 (38.5 percent) were from multiple births. See also Stanley, *supra*, note 69 at 425.

94. Brown, *supra*, note 79 at 28 and 31.

95. Joel I. Polin and William L. Frangipane, "Current Concepts in Management of Obstetric Problems for Pediatricians" (1986) 33:3 Pediatr. Clin. N. Am. 649 at 650. See also Wenstrom and Gall, *supra*, note 92 at 3, and Botting, MacDonald Davies and MacFarlane, *supra*, note 92 at 945.

96. See Polin and Frangipane, *supra*, note 95 at 650. See also Wenstrom and Gall, *supra*, note 92 at 4-5.

97. Respiratory Distress Syndrome (RDS) occurs most often in premature infants who are deficient in surfactant, a substance that promotes normal expansion of the lungs. This syndrome is especially prevalent (48 percent) in twins between 25 weeks' gestation and 32 weeks' gestation (between 15 and 8 weeks premature). See Wenstrom and Gall, *supra*, note 92 at 5.

98. Twins delivered between 25 and 32 weeks' gestation have at least a 20 percent chance of hemorrhaging into the ventricles of the brain. *Ibid.*

99. In infants weighing less than 2,500 grams the risk for Group B Streptococcal Disease was found to be five times greater in twins than in singletons. See Kristine McCulloch, "Neonatal Problems in Twins" (1988) 15:1 Clin. Perinatol. 141 at 151.

In addition to being prone to low birth weight because of prematurity, twins are also at increased risk for growth retardation.[100] Distress during labour, reduced oxygen (asphyxia), and ultimately stillbirth are all risks found in association with growth retardation.[101]

An international collaborative IVF study from 55 centres found the rate of birth defects to be only slightly higher for multiple births than for single births (3.6 compared to 2.5 percent).[102] However, studies of the long-term consequences of twin birth reveal a higher rate of learning disability, motor skill deficiency, speech problems, and delayed physical growth.[103] Risks to the mother during and following pregnancy include increased risk of pregnancy-induced high blood pressure, anemia, Cesarean birth and excessive bleeding after delivery.[104]

Approximately 15 percent of all multiple births associated with IVF are triplet or higher-order multiple pregnancies. Risks for both mother and fetus are greatly increased where there are more than two fetuses. For example, the perinatal mortality rate is approximately three times greater for triplets than for twins.[105]

(b) Lowering the Multiple Pregnancy Rate

Louise Brown was the first test-tube baby. Her birth in 1978 was the result of the in vitro fertilization of a single egg, retrieved during a natural cycle, and the transfer of the single conceptus back into the womb. In those early days, relatively primitive methods of predicting maturation and ovulation of the egg were imprecise. Retrieval of the ovum required the surgical team to be available around the clock, and even then the rate of successful retrieval was less than 50 percent. Failure at the fertilization and implantation stages compounded the problem of low success rates. In order to improve the odds, superovulation techniques were developed. They resulted in the capacity to induce several mature eggs per cycle, and better control of the timing of ovulation. Consequently, higher pregnancy rates were achieved.[106] However, as indicated above, the probability of

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100. Both terms, intra-uterine growth retardation (IUGR) and small for gestational age (SGA) describe fetuses/infants who are substantially smaller than their gestational age would indictate when compared to general population statistics of singleton fetuses. For example, a baby born after 35 weeks' gestation the size of an average 32-week baby would be considered growth retarded, and therefore at higher risk than one born at a size appropriate to its gestational period. See Polin and Frangipane, *supra*, note 95 at 657. See also Richard Bronsteen, Gregory Goyert and Sidney Bottoms, "Classification of Twins and Neonatal Morbidity" (1989) 74:1 Obstet. Gynecol. 98 at 100.

101. Polin and Frangipane, *supra*, note 95 at 657, and Bronsteen, Goyert and Bottoms, *supra*, note 100 at 100.

102. See Cohen, Mayaux and Guihard-Moscato, *supra*, note 88 at 3.

103. Wenstrom and Gall, *supra*, note 92 at 5, and Polin and Frangipane, *supra*, note 95 at 650-51.

104. Pritchard, MacDonald and Gant, *supra*, note 88 at 503.

105. Botting, MacDonald Davies and MacFarlane, *supra*, note 92 at 946.

106. G. Sher and H.C. Chotiner, "Controlled Ovarian Hyperstimulation for IVF" in Christopher M. Fredericks, John D. Paulson and Alan H. DeCherney, eds, *Foundations of In Vitro Fertilization* (Cambridge: Hemisphere, 1987) at 83.

multiple pregnancies and their attendant risks also increased. How, then, do we balance the maximum benefit derived from multiple transfers while minimizing the risk of multiple pregnancy? In other words, how many concepti should be transferred into the womb per cycle?

This question raises a number controversial issues, in particular the fact that there is no agreement as to an acceptable rate of multiple pregnancies.[107] Also, the relationship between the number of concepti transferred and the resulting number of multiple pregnancies is unclear, partly because of methods of reporting in the literature. One report, however, demonstrated that when four, five, six and seven embryos were transferred, the chances of delivering at least one baby were 18, 17, 18 and 18 percent, and the chances of multiple pregnancy were 16.7, 31.6, 50 and 50 percent respectively.[108] In other words, although the chance of delivering a baby was not greater with more than four embryos, the chance of multiple pregnancy increased substantially. Further, the same report demonstrated that the transfer of three embryos resulted in a birth rate of 12 percent, but in a multiple pregnancy rate of 21 percent.[109] A similar non-linear trend is seen in other reports (see table 3, *infra* at 36), demonstrating that pregnancy rate and multiple pregnancy rate are not determined solely by the number of embryos transferred.

Successful pregnancy is determined by the receptivity of the uterus to implantation and the "quality" of the embryos transferred.[110] At present, both uterine receptivity and embryo quality are difficult to quantify clinically. Further research is essential in this area to improve overall success rates in artificial reproduction while reducing the number of embryos that need to be transferred.[111] In the meantime, the most commonly accepted method of reducing the risk of multiple pregnancy is to limit the number of embryos transferred per treatment.

The limitation of embryo transfer has received international attention in the last few years. For example, national professional governing bodies in the U.K.[112] and in Australia have issued guidelines limiting to no more than three or (in extreme cases) four the number of embryos that may be transferred at any one time.[113] Not all practitioners have endorsed these guidelines. One British fertility team has resisted limitations, advocating a flexible approach for the number of embryos transferred in IVF or the number of eggs transferred

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107. Simon Fishel and John Webster, "IVF and Associated Techniques: Whom Can We Believe?" (1987) II:8553 Lancet 273.

108. *U.S. IVF/ET 1989*, *supra*, note 74 at 16.

109. *Ibid.*

110. Anibal A. Acosta *et al.*, "Implantation Potential of Each Pre-Embryo in Multiple Pregnancies Obtained by In Vitro Fertilization Seems to Be Different" (1988) 50:6 Fertil. Steril. 906.

111. Jan Tesarik, "Viability Assessment of Preimplantation Concepti: A Challenge for Human Embryo Research" (1989) 52:3 Fertil. Steril. 364.

112. See ILA, *supra*, note 75 at 22, and Ian Craft, Peter R. Brinsden and Eric G. Simons, "Voluntary Licensing and IVF/ET" (1987) I:8542 Lancet 1148.

113. C.R. Austin, "Voluntary Regulatory Scheme for Clinics Practising IVF and Related Technologies in Australia" (1989) 4:7 Human Reprod. 854. See also ILA, *supra*, note 75.

when using the GIFT procedure.[114] Professor Craft and his colleagues argued that limiting the number of eggs unfairly limited the chances of pregnancy in some cases; they argued that clinical judgment should prevail over strict enforcement, as is the case with most other medical procedures. For example, the chance of pregnancy and multiple pregnancy declines with advancing age,[115] perhaps warranting higher transfer numbers to achieve pregnancy. On the other hand, previous pregnancy increases the chance of multiple pregnancy. Therefore, individual risk for multiple pregnancy differs depending on such criteria as age and previous pregnancy. In addition, large variations in multiple pregnancy rates have been observed among clinics, even where the number of embryos transferred per cycle was the same.[116]

In Canada, individual clinics have policies regarding the numbers of embryos that may be transferred. Although most agree that the transfer of three or four embryos minimizes the chances of multiple pregnancy, freezing facilities are not always available for storing surplus embryos. Where adequate freezing facilities are available, surplus embryos may be frozen for future use by the couple. If the embryos are not eventually used, they may be donated, used for research or destroyed, depending on the wishes of the couple.[117]

Where freezing facilities are not available, the transfer of more than four embryos to the uterus may result in a higher-order pregnancy. If more than three embryos implant, the couple may be offered the option of selective fetal reduction.[118] Although the procedure has prompted ethical debate that both parallels and differs from the abortion issue,[119] it is generally agreed there is greater risk to all of the fetuses and to maternal health if the pregnancy continues intact than if the number of fetuses is reduced.

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114. Craft, Brinsden and Simons, *supra*, note 112; Ian Craft *et al.*, "Licensing Work on IVF and Related Procedures" (1987) I:8546 Lancet 1373; Ian Craft, "How Many Oocytes/Embryos Should Be Transferred?" (1987) II:8550 Lancet 109; Ian Craft *et al.*, "Multiple Pregnancy, Selective Reduction, and Flexible Treatment" (1988) II:8619 Lancet 1087.

115. Ian Craft *et al.*, "Analysis of 1071 GIFT Procedures — The Case for a Flexible Approach to Treatment" (1988) I:8594 Lancet 1094. Professor Craft's observation that multiple pregnancy occurs less frequently with increasing age is consistent with other reports. For example, Corson *et al.* state that the chance of multiple pregnancy declines by 9 percent per year after the age of 30. See Stephen L. Corson *et al.*, "Outcome in 242 In Vitro Fertilization-Embryo Replacement or Gamete Intrafallopian Transfer-Induced Pregnancies" (1989) 51:4 Fertil. Steril. 644 at 645. For a discussion of the effect of aging on IVF success, see also Santiago Padilla and Jairo E. Garcia, "Effect of Maternal Age and Number of In Vitro Fertilization Procedures on Pregnancy Outcome" (1989) 52:2 Fertil. Steril. 270.

116. A 12 percent multiple pregnancy rate was observed in an IVF program in France, compared to 25.4 percent observed in a program in Belgium, both units adhering to a policy that allows a maximum of three embryos transferred per attempt. See Frydman *et al.*, *supra*, note 78 at 553. See also P. Barlow *et al.*, "Early Pregnancy Loss and Obstetrical Risk after In-Vitro Fertilization and Embryo Replacement" (1988) 3:5 Human Reprod. 671 at 675.

117. For discussion of frozen embryos, see *infra* at 29; see also A. Trounson, "Embryo Cryopreservation" in Wood and Trounson, eds, *supra*, note 51, 127 at 138-39.

118. Selective feticide is referred to in the literature as selective reduction of fetuses, selective embryocide, selective abortion or selective birth. The procedure eliminates one or more fetuses in the pregnancy.

119. "Selective Fetal Reduction" (1988) II:8614 Lancet 773.

The risks associated with the reduction techniques include spontaneous abortion of the pregnancy, failure to destroy the fetus, risk of infection and, rarely, a clotting disorder that may threaten the remaining fetuses or the mother herself.[120] The emotional cost of selective fetal reduction to the mother, father, and existing children is unknown; therefore, counselling should perhaps be considered prior to or following the procedure or both.

Clearly, the problem of multiple pregnancies is one that requires more research. However, a promising experimental IVF procedure suggests it may be possible to reduce the multiple pregnancy rate to that of the general population. In one small trial, a 22.5-percent clinical pregnancy rate with an ongoing pregnancy rate of 17.5 percent per cycle was obtained using an unstimulated cycle;[121] this is as good as or better than results using superovulation techniques. By not using ovulatory stimulation drugs, the procedure eliminates risks associated with drugs.[122] Moreover, a better quality egg and optimum uterine receptivity are more likely to result from the natural cycle. Because the procedure involves minimal invasiveness, the possibility of more frequent, repeated attempts may provide a greater overall chance of pregnancy. Non-medical advantages include lower cost[123] and the elimination of ethical and legal issues regarding surplus embryos. It is too early, however, to tell whether these results will be found to be repeatable in other clinics. The main disadvantage of this procedure is failure to retrieve an egg in 10 to 30 percent of cases, and cancellation of cycles because of imprecise hormonal determinations.[124]

(c) Birth Defects

It is difficult to determine if rates of birth defects in infants conceived by means of IVF are higher than would be expected among infants conceived by natural means. Extraneous factors that could lead to a greater incidence of birth defects following IVF may include an older age group (risking chromosomal abnormalities and other hereditary defects), an increased number of multiple births, the underlying causes of infertility, and various clinical procedures including manipulation of gametes and embryos. Among 1,694

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120. Ronald J. Wapner *et al.*, "Selective Reduction of Multifetal Pregnancies" (1990) 335:8681 Lancet 90 at 91. For a complete discussion of the history of the procedure and risks, see Fay O. Redwine and Patricia M. Hays, "Selective Birth" (1986) 10:1 Seminars Perinat. 73 at 75-78.

121. Fertility drugs are not used in the unstimulated cycle. The egg naturally matures and is retrieved, fertilized, and transferred, thereby eliminating concern regarding multiple pregnancy and surplus embryos. Hervé Foulot *et al.*, "In Vitro Fertilization without Ovarian Stimulation: A Simplified Protocol Applied in 80 Cycles" (1989) 52:4 Fertil. Steril. 617 at 617-21. See also Jairo Garcia, "Return to the Natural Cycle for In Vitro Fertilization (Alleluia! Alleluia!)" (1989) 6:2 J. In Vitro Fert. Embryo Transfer 67 at 67-68.

122. For a discussion of risks associated with ovulatory stimulation drugs, see Kennedy and Adashi, *supra*, note 33; see also *supra* at 8-9 and 12, and Navot *et al.*, *supra*, note 55.

123. The cost of the procedure is estimated to be reduced from US$6,000 to US$1,000 per attempt. See Garcia, *supra*, note 121 at 68.

124. Personal communication, Dr. E. Hughes, McMaster University, Hamilton, Ontario.

IVF births in Australia and New Zealand between 1979 and 1986, major congenital malformations, including chromosomal abnormalities, were reported at 2.2 percent (compared to 1.5 percent in the rest of the population).[125]

It has been suggested that the higher rate of abnormalities may have reflected observer bias, in that infants conceived by means of IVF might have been more carefully evaluated for abnormalities than children conceived naturally.[126] Therefore, it is suggested that large, systematic studies be carried out to determine if infants conceived using IVF are in fact at greater risk for malformation.

At the time this working paper was being prepared, Canadian congenital abnormality rates for infants conceived by IVF were not available.[127] It has been recommended that registries include this information when reporting outcomes of pregnancies conceived by artificial procreation.[128]

(d) Psychological Impact

The psychological impact of IVF procedures on couples is not apparent from a simple description of techniques and outcomes. One author who interviewed 20 Canadian women who underwent IVF found that for most of them the procedure was extremely stressful, both physically and emotionally. A profound fear of "cancellation" at each of the steps leading to embryo transfer prevailed. They also experienced "intense psychological conflict" between hopefulness and realism regarding their chances of achieving pregnancy.[129]

The stresses of infertility and IVF are such that, in Australia, legislation requires counselling both prior to and following IVF.[130] Indeed, Ontario Medical Association guidelines for IVF state that counselling should be available to all couples.[131]

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125. Paul A.L. Lancaster, "Congenital Malformations after In-Vitro Fertilisation" (1987) II:8572 Lancet 1392 (letter). Two types of birth defects, spina bifida (incomplete closure of the spine) and a serious heart abnormality (transposition of the great vessels), were significantly increased compared to the general population.

126. Eighty-three children conceived using IVF and 93 naturally conceived children were compared in a single-blind study. No statistically significant increase of abnormalities was seen. Although reassuring about large increases in abnormalities, the authors caution that the sample size was not significant enough to enable detection of small or moderate increases. See Norma C. Morin *et al.*, "Congenital Malformations and Psychosocial Development in Children Conceived by In Vitro Fertilization" (1989) 115:2 J. Pediatr. 222 at 226.

127. Brown, *supra*, note 79 at 31.

128. See ILA, *supra*, note 75 at 34. See also Ontario Medical Association, *supra*, note 85.

129. See Linda S. Williams, "No Relief until the End: The Physical and Emotional Costs of In Vitro Fertilization" in Christine Overall, ed., *The Future of Human Reproduction* (Toronto: Women's Press, 1989) at 120.

130. Paul Bravender-Coyle, "In Vitro Fertilization and the Law in Australia" (1986) 6:3 Health L. Can. 61 at 64.

131. Ontario Medical Association, *supra*, note 85 at 28.

B. Gamete Intrafallopian Transfer (GIFT)

In gamete intrafallopian transfer (GIFT), eggs and sperm are transferred, unfertilized, directly into the fallopian tubes.[132] Superovulation is practised because increased numbers of eggs improve the chance of successful pregnancy. With the use of a laparoscope, mature eggs are aspirated from the follicles, mixed with sperm, and placed in a syringe. The mixture is then transferred back deep into the fallopian tubes, allowing fertilization to occur naturally. The entire procedure takes approximately 35 to 60 minutes.[133]

This procedure is not indicated for those candidates with fallopian tube disease because of the risk of ectopic pregnancy.[134] Therefore, although indications for GIFT overlap those for IVF (unexplained infertility, endometriosis, male factor, cervical or immunologic reasons), they exclude the largest group of candidates for IVF, those with tubal disease.[135]

The primary advantage of GIFT is that the requirement for laboratory facilities is minimized. The major drawback is that a general anesthetic is necessary because of the laparoscopy. Thus, the invasiveness of the procedure is greater than with IVF as practiced in most centres. This may be a temporary problem, since some reports have shown that egg retrieval and transfer is possible using vaginal ultrasound-guided methods.[136] As technical mastery of this procedure becomes more widespread, the use of laparoscopy for GIFT should decline.

1. Success Rates

An international collaborative study of the first 800 cases of GIFT procedure, using a common GIFT protocol per egg retrieval, yielded a 34.4-percent clinical pregnancy rate and a delivery rate of 25 percent.[137] National reports from the U.S., U.K. and Australia demonstrated rates of clinical pregnancy ranging from 21 to 25 percent per transfer cycle,[138] which is higher than the 17- to 21-percent rate seen in IVF using a similar criterion of pregnancy.[139] Miscarriage rates were not provided in the U.K. data, so an ongoing pregnancy rate could not be calculated. However, an 18-percent delivery rate per egg retrieval was reported in the U.S. and Australian reports. The occurrence of multiple pregnancy is slightly higher than with IVF, ranging from 20 to 28 percent.[140]

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132. Seibel, *supra*, note 48 at 832.

133. R.H. Asch *et al.*, "Gamete Intrafallopian Transfer: International Cooperative Study of the First 800 Cases" (1988) 541 Ann. N.Y. Acad. Sci. 722 at 724.

134. See David L. Olive *et al.*, "Gamete Intrafallopian Tube Transfer (GIFT) Complicated by Bilateral Ectopic Pregnancy" (1988) 49:4 Fertil. Steril. 719 at 720.

135. See P.A.L. Lancaster, "Outcome of Pregnancy" in Wood and Trounson, eds, *supra*, note 51, 81 at 82; Asch *et al.*, *supra*, note 133 at 723; and Yuzpe *et al.*, *supra*, note 65 at 168.

136. R.P.S. Jansen, "Gamete Intra-fallopian Transfer" in Wood and Trounson, eds, *supra*, note 51, 63 at 72.

137. Asch *et al.*, *supra*, note 133 at 722-25.

138. See table 2, *infra* at 36.

139. See table 1, *infra* at 35. The clinical pregnancy rate is based on the number of embryo transfers.

140. See table 2, *infra* at 36 for details.

Once again, compiled national data reports demonstrate lower average success rates than those reported from individual centres.[141]

2. Complications

The collaborative study of 800 cases demonstrated no immediate major complications due to the procedure or to anesthesia, nor were any cases of induced pelvic inflammatory disease reported,[142] but the usual risks of anesthesia and laparoscopy remain. Although the ectopic pregnancy rate appears to be no higher than that seen in IVF,[143] it has been reported to be as high as 30 percent when undetectable tubal disease is present.[144]

C. Other Procedures

Several other variants of IVF and GIFT have been reported. These include peritoneal oocyte and sperm transfer (POST), pronuclear stage transfer (PROST), and tubal embryo stage transfer (TEST).

POST involves the transfer of oocytes and sperm through the posterior vaginal wall, by means of a needle, using the normal fluid in the abdominal cavity as a medium for transfer into the fallopian tube. PROST involves insemination of eggs in vitro and their transfer directly into the fallopian tubes. TEST is the transfer of early-stage embryos (frozen at a four-to-eight-cell stage[145]) into the fallopian tubes. None of these procedures has been used on a large scale, and they have not been reported from Canadian centres.

One variant of IVF and GIFT is referred to as IVC or intravaginal culture; this has been reported from a Canadian centre.[146] Eggs and sperm are placed in a small tube and allowed to incubate for about two days in the vagina of the recipient. The tube is held in place by a vaginal diaphragm. Later, the concepti are transferred into the uterus. This technique offers the advantage of simplifying laboratory manipulations and decreasing the cost of the procedure. A preliminary random study showed there was no difference in pregnancy rates between IVC and IVF.

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141. C. Borrero *et al.*, "The GIFT Experience: An Evaluation of the Outcome of 115 Cases" (1988) 3:2 Human Reprod. 227. See also Christopher J. Haines and Robert T. O'Shea, "Unilateral Gamete Intrafallopian Transfer: The Preferred Method?" (1989) 51:3 Fertil. Steril. 518 at 519.

142. Asch *et al.*, *supra*, note 133 at 724.

143. Ectopic pregnancy is reported to be between 3 and 6 percent, similar to reports of IVF but higher than the general population risk of 1.5 percent. See Asch *et al.*, *supra*, note 133 at 724; and Borrero *et al.*, *supra*, note 141 at 228. See also *supra*, note 89.

144. Jansen, *supra*, note 136 at 73.

145. See John L. Yovich, Jeanne M. Yovich and W. Rohini Edirisinghe, "The Relative Chance of Pregnancy Following Tubal or Uterine Transfer Procedures" (1988) 49:5 Fertil. Steril. 858 at 859-60 for a description of PROST and TEST. See also Vinay Sharma, Bridgett Mason and Stuart Campbell, "Ultrasound-Guided Peritoneal Oocyte and Sperm Transfer" (1988) 541 Ann. N.Y. Acad. Sci. 767 (Discussion of POST).

146. Claude Ranoux *et al.*, "A New In Vitro Fertilization Technique: Intravaginal Culture" (1988) 49:4 Fertil. Steril. 654 at 656.

D. Artificial Insemination

The first successful cases of artificial insemination, the simplest and oldest of the reproductive technologies, were first reported in the literature in the 1770s.[147] It is currently estimated that in North America between 10,000 and 20,000 infants are conceived each year as a result of artificial insemination.[148] As a solution to male infertility, it is simple, non-invasive and relatively inexpensive, although some new AI procedures are beginning to approach the levels of invasiveness of other reproductive procedures.[149]

Artificial or therapeutic insemination may be performed using the sperm of the husband/partner (AIH) or of a sperm donor (AID). AID is most often performed after male infertility has been established and medical treatment has been unsuccessful.[150] Donor sperm is also indicated in some cases where either partner is carrying a genetic disease.[151]

Artificial insemination by the husband/partner is indicated in fewer than 20 percent of couples where male infertility is present. In some, bypassing of the vaginal secretions by the sperm may be sufficient to allow fertilization. Other indications for AIH include anatomic abnormalities of the male, such as hypospadias, where the opening of the urethra is situated in a place other than the end of the penis, or a maternal abnormality such as a malpositioned uterus.[152]

1. The AI Procedure

It is generally accepted that donor sperm should be frozen prior to use. Frozen sperm is recommended because screening can be done to reduce the risk of transmitting infectious

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147. For a discussion of the history of AI, see Derek J. Jones, "Artificial Procreation, Societal Reconceptions: Legal Insight from France" (1988) 36 Am. J. Comp. L. 525 at 530-33.

148. Barbara Eck Menning, "The Psychology of Infertility" in James Aiman, ed., *Infertility: Diagnosis and Management* (New York: Springer-Verlag, 1986) 17 at 23. Also, a 1981 Canadian report stated that about 500 inseminations were done each month at Canadian clinics and more than 1,500 babies had been born at that time as a result of AID. See *Report of the Advisory Committee on the Storage and Utilization of Human Sperm* (Ottawa: Health and Welfare Canada, 1981) at x-xi [hereinafter *Report on Human Sperm 1981*].

149. DIPI, or Direct Intraperitoneal Insemination, is a procedure in which sperm is deposited by means of a needle and tube, through the posterior portion of the vagina into a space containing fluid near the ovaries and the fallopian tube, thus bypassing the uterus. See P. Dellenbach *et al.*, "Direct Intraperitoneal Insemination: New Treatment for Cervical and Unexplained Infertility" (1988) 541 Ann. N.Y. Acad. Sci. 761. See also Jansen, *supra*, note 136 at 72.

150. Alexander and Ackerman, *supra*, note 38 at 907-08.

151. Between 1 and 10 percent of AI is performed to prevent the inheritance of a genetic disease. See James Aiman "Artificial Insemination" in Aiman, ed., *supra*, note 148 at 277. Also see Pierre Jalbert *et al.*, "Genetic Aspects of Artificial Insemination with Donor Semen: The French CECOS Federation Guidelines" (1989) 33 Am. J. Med. Genet. 269 at 272.

152. Keller, Strickler and Warren, *supra*, note 28 at 203-04.

diseases such as AIDS,[153] availability of specimens from the same donor for repeated inseminations is increased, and possibilities are better for the matching of recipient characteristics with donors.[154]

The storage of sperm for future use by an individual male is another reason that sperm may be frozen. For example, permanent destruction of the capacity to produce sperm can be a side-effect of radiation therapy for some cancers.[155] Therefore, banking of sperm prior to radiation may be desirable.

Insemination is the delivery of sperm through a syringe into the vagina, the cervix, or the uterus. Improved rates of pregnancy have been achieved using an ultrasound-guided tube to deposit sperm directly into the fallopian tube, but this procedure is still experimental.[156]

Timing is essential to the success of artificial insemination. Since sperm survives approximately 48 hours, one insemination one to two days prior to the expected time of ovulation, and another insemination 48 hours later, should provide sufficient coverage of the fertile interval.[157] The timing of ovulation can be determined with a certain accuracy by the charting of body temperature, ultrasound measurement of follicular growth, and measurements of hormone levels.[158]

2. Outcomes

Most studies of clinical pregnancy rates for AID employed fresh (that is, unfrozen) semen samples. These are comparable to results achieved with natural insemination: about 20 percent per cycle, approaching 95 percent by the end of six cycles. Studies have demonstrated that freezing sperm reduces its motility, longevity and fertilizing capacity by half. Cumulative pregnancy rates are approximately half those expected with fresh semen, and several more treatment cycles, on average, are necessary to achieve conception using frozen sperm.[159] The rate of spontaneous abortions, however, is not elevated where frozen sperm is used.[160] As with other artificial reproductive techniques, pregnancy rates are influenced by maternal age and fertility.[161]

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153. See discussion *infra*, note 181.

154. Alexander and Ackerman, *supra*, note 38 at 919.

155. Philip Rubin and Richard F. Bakemeier, *Clinical Oncology: A Multidisciplinary Approach*, 6th ed. (New York: American Cancer Society, 1983) at 352. See also Jones, *supra*, note 147 at 527.

156. Jansen, *supra*, note 136 at 72.

157. Keller, Strickler and Warren, *supra*, note 28 at 211, and Aiman, *supra*, note 151 at 282.

158. Aiman, *supra*, note 151 at 281-82.

159. The French Federation CÉCOS (Centres d'études et de conservation du sperme humain) has collected data on about 17,000 pregnancies achieved using frozen sperm. The success rate per cycle is about 8 percent, with a cumulative success rate of 66 percent at 12 months. See D. Le Lannou and J. Lansac, "Artificial Procreation with Frozen Donor Semen: Experience of the French Federation CÉCOS" (1989) 4:7 Human Reprod. 757 at 759.

160. Jon Alfredsson, "Incidence of Spontaneous Abortion Following Artificial Insemination by Donor" (1988) 33:4 Int. J. Fertil. 241 at 244.

161. Le Lannou and Lansac, *supra*, note 159 at 760. See also Christopher L.R. Barratt, Mayur Chauhan and Ian D. Cooke, "Donor Insemination — A Look to the Future" (1990) 53:3 Fertil. Steril. 375 at 382.

The indication for AIH will determine the success rate: AIH is the least effective fertilization technique if the problem is with the husband's/partner's sperm.[162] However, couples treated because of male anatomical abnormality will have high success rates.

3. AI Risks

The main risks associated with AID are: infection; transmission of genetic disease; consanguinity, if the same donor is used too many times in a small centre;[163] administration errors in matching donor with recipient; and risks associated with intra-uterine insemination.

The risk of infection increases when the semen is introduced into the cervix and the uterus. Untreated semen may contain disease-causing organisms such as the gonococcus, chlamydia or HIV. The practice of storing sperm until adequate screening can be done greatly reduces the risk of infectious-disease transmission.[164]

Women receiving intra-uterine insemination either by donor or husband may experience uterine contractions and, more rarely, low blood pressure, slowed heart rate and weakness. Medical precautions can be taken to minimize such effects.[165]

The risk of genetic-disease transmission is reduced if donors are adequately screened, enabling the couples to be informed, prior to acceptance, of potential risks for genetic disease in their offspring. This is discussed more fully elsewhere in the text. Consanguinity risks are minimized where donors are "retired" after a number of donations. The smaller the size of the community served by a clinic, the fewer times an individual should be permitted to donate sperm.

4. Donors

The usual practice is that sperm donors are anonymous to recipients. Medical students and other university students often act as sperm donors, perhaps because of their proximity to fertility clinics. However, in some places sperm donors may be sought through advertisements in the media.[166] Canadian centres usually operate their own sperm banks and in some circumstances may also import sperm from such places as New York and California.[167]

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162. Spark, *supra*, note 28 at 336. See also *supra*, note 39.

163. If the same donor is used too many times, theoretically there is a risk that biologically related offspring, without knowledge of paternity, may meet and reproduce, risking genetic abnormality to their offspring. In fact, it has been calculated that the risk of two half-siblings (resulting from AID in a large centre) meeting and reproducing is extremely low (less than 1/1000). Aiman, *supra*, note 151 at 284. The risk of consanguinity would depend on the size of the community served.

164. See "Screening Gamete and Embryo Donations," *infra* at 32.

165. These effects can often be reversed with the use of aspirin. See Aiman, *supra*, note 151 at 284.

166. Canadian Fertility and Andrology Society, *supra*, note 11 at 5.

167. See *Report on Human Sperm 1981*, *supra*, note 148 at 13ff.

E. Ovum and Embryo Donation

Ovum donation is becoming an increasingly popular reproductive option for some sterile individuals, for example those with premature menopause. In 1987, in fact, 17 U.S. centres reported using donated eggs for IVF/GIFT procedures as compared to only one centre in a 1985-86 report.[168] Ovum donation is most often indicated where the recipient's ovaries are absent or malfunctioning, or where she is carrying a gene for a genetic disorder.[169]

Embryo donation is the practice of donating an embryo that is genetically unrelated to the recipient couple. Embryos may be available for donation from those undergoing IVF where there is an excess number of embryos for their own purposes.

Embryo freezing both creates and diminishes medical and legal ethical dilemmas. Embryo freezing delays but does not eliminate the burden of disposal of embryos which, if not used, will have to be dealt with eventually. The main advantages of embryo freezing are that: the procedure allows for a limitation of the number of fresh embryos reimplanted in an IVF cycle, therefore reducing the risk of multiple pregnancy; if the first IVF cycle is not successful, it allows for future attempts in natural cycles without further egg retrieval; it allows for simplified development of embryo-donation programs.

Limited cell damage is allowable during the freeze-thaw procedure without detrimental effects on the early conceptus because at this stage all cells have the capacity to develop fully into an embryo. Therefore, a conceptus frozen at the four-cell stage may survive the thawing procedure with three cells remaining and yet retain normal developmental potential.[170]

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168. *U.S. IVF/ET 1989*, *supra*, note 74 at 17. See also Medical Research International and American Fertility Society Special Interest Group, "In Vitro Fertilization/Embryo Transfer in the United States: 1985 and 1986 Results from the National IVF/ET Registry" (1988) 49:2 Fertil. Steril. 212 at 214 [hereinafter *U.S. IVF/ET 1988*].

169. J. Leeton, A. Trounson and C. Wood, "The Use of Donor Eggs and Embryos in the Management of Human Fertility" (1984) 24:4 Aust. N.Z. J. Obstet. Gynaec. 265.

170. Trounson, *supra*, note 117 at 140. An international survey of 24 centres, completed in December 1986, showed that of 3577 frozen embryos, approximately 50 percent were suitable for replacement. A 13-percent pregnancy rate per transfer and a 26-percent spontaneous abortion rate were demonstrated. The delivery rate was unclear, since singletons were not differentiated from multiple pregnancies. André C. Van Steirteghem and Etienne Van Den Abbeel, "Survey on Cryopreservation" (1988) 541 Ann. N.Y. Acad. Sci. 571. For further information on success rates for pregnancies achieved through the use of frozen embryos, see Jacques Testart, "Results of In Vitro Fertilization with Embryo Cryopreservation and a Recommendation for Uniform Reporting" (1988) 49:1 Fertil. Steril. 156.

1. The Ovum Donation Procedure

General egg retrieval procedures have been described elsewhere in this chapter.[171] Methods of egg retrieval by lavage have been described in the literature, although they are not used in Canada. This involves the donor undergoing superovulation, with or without insemination. Eggs or concepti are flushed from the uterus with a solution.[172]

If the recipient has normal ovulatory cycles, the cycles of the donor and recipient must be synchronized to ensure that the uterine lining of the recipient is ready for implantation. If the recipient does not have normal cycles, as in premature menopause, hormones are administered to mimic a normal cycle. At the time of transfer of the concepti or gametes, the recipient's hormonal levels must be sufficient to allow implantation, and must be maintained until the placenta of the developing embryo takes over the task of producing the hormones that maintain pregnancy, approximately 8 to 12 weeks later.[173]

2. Ovum Donors

The potential pool of ovum donors consists of: women undergoing egg retrieval for their own reproductive purposes; women undergoing sterilization; volunteer, anonymous donors; and known donors (friends or relatives recruited by the recipient).[174]

The process of superovulation and egg retrieval carries with it a small medical risk. Whether this risk is reasonable when donation occurs for purely altruistic reasons is still the subject of debate. Those undergoing the procedure for their own reproductive purposes, where the number of eggs obtained is in excess of individual needs, are probably the most suitable candidates for donation. The availability of eggs through this source becomes limited, however, where freezing facilities are available, because couples undergoing egg retrieval are likely to choose to have excess eggs fertilized, and the concepti frozen for their own future use.[175]

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171. *Supra* at 12-13.

172. Mark V. Sauer, Robert E. Anderson and Richard J. Paulson, "A Trial of Superovulation in Ovum Donors Undergoing Uterine Lavage" (1989) 51:1 Fertil. Steril. 131. The method of concepti donation following superovulation, insemination and lavage is considered unacceptable in some jurisdictions because of the substantial risk of unwanted pregnancy to the donor. See P.A.W. Rogers *et al.*, "Oocyte Donation" in Wood and Trounson, eds, *supra*, note 51, 143 at 146.

173. Rogers *et al.*, *supra*, note 172 at 148-51.

174. *Ibid.* at 145-46.

175. Freezing of eggs is not an established practice at this time, although four children have been born worldwide with the use of frozen-thawed eggs. The human egg is especially vulnerable to damage during the freeze-thaw process. The risk is of abnormality during subsequent cell division, resulting in an abnormal number of chromosomes; also, the protective coverings surrounding the egg may be damaged, allowing more than one sperm to fertilize the egg. More study is needed in this area to determine if there is indeed a future in the freezing of human eggs. Trounson, *supra*, note 117 at 138-39. See also Christopher Chen, "Pregnancies after Human Oocyte Cryopreservation" (1988) 541 Ann. N.Y. Acad. Sci. 541 at 547.

Known donors are used frequently.[176] The literature suggests that caution should be exercised, in that the future of the psychological relationship between the child, the birth mother and the egg donor is an important consideration.[177] Further, if egg donation is employed to avoid transmission of genetic disorders, family members may not be appropriate donors. To avoid a substantial risk of genetic abnormality due to consanguinity, the husband's sister is not a suitable candidate except when donor sperm is used.

Finally, women undergoing sterilization procedures are suitable donors.[178] In these cases, individuals have already decided to undergo the invasive procedure of sterilization; therefore the only added risk is that of superovulation.

F. Surrogacy

In the context of this working paper, a surrogate is a woman who agrees to gestate a pregnancy with the intention of surrendering the newborn infant to the "social" or "contracting" parents. Leaving aside the important ethical and legal issues to which this phenomenon gives rise, there are three general medical circumstances in which surrogacy may be indicated:[179] (1) absence or significant abnormality of the uterus (where surrogacy would be the only possible way of producing a child); (2) cases in which there is environmental risk to the developing fetus (such as when the mother, for her own health, must on a continuing basis take medications that may be harmful to a developing fetus); or (3) when pregnancy poses a substantial threat to maternal health, as in the case of severe heart disease. The latter two situations suggest a safer environment for pregnancy, but are not considered absolute indications.

There are several possible combinations of parentage between the surrogate and future parents. The egg may originate from the surrogate or the contracting woman or it may be donated by a third party. The sperm may be the contracting father's or it may be donated sperm. In all, six combinations of biological parentage are possible.

Methods of fertilization nearly as numerous can be classified under two categories: (1) in vitro fertilization; and (2) in vivo fertilization, including GIFT, artificial insemination, and natural insemination. In vitro fertilization and GIFT are more likely to be used in cases where the egg is not contributed by the surrogate.

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176. Mark V. Sauer *et al.*, "Survey of Attitudes Regarding the Use of Siblings for Gamete Donation" (1988) 49:4 Fertil. Steril. 721.

177. See discussion ILA, *supra*, note 75 at 15. After a multidisciplinary meeting about egg donation, it was decided that, like sperm donors, egg donors should remain anonymous (*Authority's Guideline* 13(j), *ibid.* at 47).

178. Rogers *et al.*, *supra*, note 172 at 146. An added advantage of this group as donors is that their fertility has in most cases already been demonstrated.

179. For a discussion of pregnancy that poses substantial risk to the mother or the fetus, see Pritchard, MacDonald and Gant, *supra*, note 88 at 494, 592, 608 and 802.

Surrogate embryo transfer (SET), in which the egg of the donor is fertilized in vivo by artificial insemination, collected by lavage and transferred to the gestational mother, is sometimes included under the category of surrogacy, but in this chapter it is discussed under the heading of ovum and embryo donation.[180]

V. Screening Gamete and Embryo Donations

Sperm donation is now a well-accepted palliative to infertility, and with the further development of simpler egg-retrieval techniques it is foreseeable that ovum donation will also become widely used. The major risk to the recipient associated with gamete donation is the transmission of infectious diseases. For the resulting offspring, the risks are not only of infectious disease (such as cytomegalovirus), but also of genetic abnormality. Although the merits of screening for both infectious and genetic diseases have been widely discussed and internationally advocated, there is reasonable concern that some clinics may choose not to follow recommendations for screening[181] established by such professional groups as The American Fertility Society[182] and the Canadian Fertility and Andrology Society.[183]

The probability of transmitting the AIDS virus through donated semen, although very rare, has led to firm recommendations that all donor semen in Canada be frozen and stored for at least six months, until the donor is retested for evidence of the virus. This is necessary because evidence of seropositivity in the donor's blood may not be detectable for some time after exposure.[184]

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180. See *supra*, note 172.

181. A survey of 11,000 physicians participating in AID in the U.S., completed in 1987, found that one-fifth of centres surveyed did not screen donors for sexually transmitted diseases and fewer than half screened for genetic diseases. Further, of those that did screen for genetic diseases, many did not screen appropriately; for example, donors were rejected unnecessarily in some cases and in other cases accepted when there was significant risk. See OTA, *Artificial Insemination: Practice in the United States* (Washington, D.C.: OTA, 1988) at 8, 33-40. Also, in 1984 an Ontario Law Reform Commission survey of 16 physicians performing AID in Ontario found that donor screening practice varied considerably. See OLRC, *supra*, note 2 at 22 n. 36-38; see also Barratt, Chauhan and Cooke, *supra*, note 161.

182. The American Fertility Society, "New Guidelines for the Use of Semen Donor Insemination: 1990" (1990) 53:3 (Supp. 1) Fertil. Steril. 1Sff; see also *infra*, note 186.

183. Canadian Fertility and Andrology Society, *supra*, note 11 at 3. Guidelines for Therapeutic Donor Insemination were adopted in October 1988, stating: "Rigorous attention must be paid to all aspects of donor screening and management to reduce the risks of transmitting genetic or other diseases to the recipients to the absolute minimum possible level in accordance with all currently available screening and testing procedures."

184. Six cases of HIV infection have occurred via donated frozen semen (four in Australia and two in Canada). See Supplement to Health and Welfare Canada, Federal Centre for AIDS, "Guidelines for Prevention of HIV Infection in Organ and Tissue Transplantation" (October 1989) 15S4 (Supp.) Canadian Diseases Weekly

Other transmissible diseases that should be screened for include hepatitis, cytomegalovirus, herpes, gonorrhea, chlamydia and mycoplasma. This is done by culture of the semen or through blood tests.[185] Careful screening of the donor with regard to lifestyle and medical and sexual history also reduces the risk of transmitting infectious diseases by rejection of high-risk donors.[186]

Ovum donors should be screened in the same manner as sperm donors even though it is not known whether the organisms in question can be transmitted by ova.[187] Since ovum freezing is not common,[188] the time span between donation and acceptance of the ovum by the recipient is limited. Therefore, prompt screening to the extent possible should be carried out to ensure the safety of the recipient and her potential pregnancy.[189] The risk of passing on genetic disease through ovum donation is the same as or even greater than with sperm donation, since there is the added risk of X-linked disorders. Thus, even under time restrictions, it is important that screening guidelines for genetic disease be followed in order that the recipient be fully informed and thus able to make decisions regarding the degree of potential risk.[190]

Report 1 at 2. A more recent report from New York City found that infected semen from six donors was used in 178 women and one women was recently found to be seropositive. On this issue see Mary Ann Chiasson, Rand L. Stoneburner and Stephen C. Joseph, "Human Immunodeficiency Virus Transmission through Artificial Insemination" (1990) 3 J. Acquired Immune Deficiency Syndrome 69. See also Canadian Fertility and Andrology Society, *supra*, note 11 at 3, which states that "there is no place for fresh semen in TDI [AID]. Semen cryopreservation must be used in conjunction with repeated AIDS screening of the donors so that only semen which has been quarantined for an absolute minimum period of 6 months (and, wherever possible 12 months) be used." See also Edwin P. Peterson, Nancy J. Alexander and Kamran S. Moghissi, "A.I.D. and AIDS: Too Close for Comfort" (1988) 49:2 Fertil. Steril. 209; Barratt, Chauhan and Cooke, *supra*, note 161.

185. Canadian Fertility and Andrology Society, *supra*, note 11 at 5.

186. *Ibid.*; and Ruth M. Greenblatt *et al.*, "Screening Therapeutic Insemination Donors for Sexually Transmitted Diseases: Overview and Recommendations" (1986) 46:3 Fertil. Steril. 351.

187. The American Fertility Society, The Ethics Committee, "Ethical Considerations of the New Reproductive Technologies" (1986) 46:3 (Supp. 1) Fertil. Steril.

188. See *supra*, note 175.

189. For an extensive discussion of screening, see Jalbert *et al.*, *supra*, note 151 at 269-75; and F. Clarke Fraser and R. Allan Forse, "On Genetic Screening of Donors for Artificial Insemination" (1981) 10 Am. J. Med. Genet. 399. Canadian Fertility and Andrology Society, *supra*, note 11 at 16; see also The American Fertility Society, *supra*, note 182.

190. The Canadian Council of Medical Geneticists is currently developing guidelines for genetic screening of ovum donors (Personal communication, Dr. F.C. Fraser).

Embryo donation carries with it the added (but necessary) burden of genetic screening of both parents. Ideally, the data should be kept in a registry in the event that an abnormality occurs at birth or a genetic disorder develops at a later time.[191] Surrogacy should require the same stringent screening procedures for sexually transmitted and genetic diseases.

To underscore the importance of all this, we might consider the following: the case of a surrogate who, unbeknownst to the contractual parents, was HIV positive. Subsequently, it was discovered that the newborn child was also seropositive. Both the contractual parents and the surrogate decided against keeping the child. Even though the contractual mother and the surrogate were sisters, the surrogate did not reveal that she was a drug addict and therefore at high risk for contracting the AIDS virus.[192] This illustrates that even in the case of known donors appropriate screening should be undertaken; most importantly, it demonstrates the consequences the child may have to bear in the absence of it.

191. The literature suggests that in the case of gamete and embryo donation, record keeping (using codes to protect the anonymity of both donors and recipients) allowing the donor to be notified in the case of abnormality of the child may be important. One report suggests that notification is warranted when the condition is severe, carries a risk of recurrence (for future offspring) and is preventable. See Jalbert *et al.*, *supra*, note 151 at 272. It appears that appropriate notification of donors should be subject to further discussion.

192. Winston R. Frederick *et al.*, "HIV Testing of Surrogate Mothers" (1987) 317:21 New Engl. J. Med. 1351 (letter).

TABLE I: IVF International Results

Countries	Number of Hormone Cycles (HC)	Number of Couples Treated (CT)	Number of Embryo Transfers (ET)	Number of Clinical Pregnancies (CP)	CP/HC	CP/CT	Number of Miscarriages (M)	M/CP	Number of Ectopic Pregnancies (EP)	EP/CP	Number of Deliveries (D)	D/HC	Number of Live Births (LB)	LB/HC	Number of Multiple Births (MB)	MB/D
Canada																
1982–88	5 921	3 277	4 474	667	11.3%	20.4%	150	22.5%	47	7%	—	—	460	7.9%	—	—
United Kingdom																
1988	10 489	7 515	6 553	1 354	12.9%	18%	264	19.5%	69	5%	—	—	956	9%	—	24%
Australia and New Zealand																
1986	4 507	—	—	612	13.6%	—	159	26%	36	5.8%	417	9.3%	—	—	—	—
1979–1985	—	—	—	1 259	—	—	—	24.3%	65	5.2%	902	—	1 138	—	—	22.4%
United States																
1987	—	—	7 561	1 367	—	—	344	25%	103	7.5%	991	—	1 260	—	—	24%
1986	4 867	3 055	2 864	485	10%	16.9%	151	31.1%	22	4.5%	—	—	311	6.4%	—	—

Sources: Canada: Brown, *supra*, note 79 at 28, 31. **United Kingdom:** *The Fifth Report of the Interim Licensing Authority for Human In Vitro Fertilisation and Embryology 1990*, *supra*, note 75 at 20-22. **Australia and New Zealand: 1986:** Stanley, *supra*, note 69 at 425; **1979-85:** Australian In-Vitro Fertilization Collaborative Group, *supra*, note 73 at 429-36. **United States: 1987:** Medical Research International and the Society of Assisted Reproductive Technology, *supra*, note 74 at 13-18; **1986:** Medical Research International and American Fertility Society Special Interest Group, *supra*, note 168 at 213-14.

TABLE II: GIFT International Results

Countries	Number of GIFT Procedures (GP)	Number of Clinical Pregnancies (CP)	CP/GP	Number of Miscarriages (M)	M/CP	Number of Ectopic Pregnancies (EP)	EP/CP	Number of Deliveries (D)	D/GP	Number of Live Births (LB)	Number of Multiple Births (MB)	MB/D
United Kingdom 1988	3 392	707	21%	—	—	—	—	—	—	—	139	20%
Australia 1986	607	136	22%	21	15%	7	5%	108	18%	—	—	—
United States 1987	1 968	492	25%	116	24%	30	6%	362	18%	489	103	28%

Sources: United Kingdom: *The Fifth Report of the Interim Licensing Authority for Human In Vitro Fertilisation and Embryology 1990, supra*, note 75 at 20-22. **Australia:** Jones, Jr. and Rogers, *supra*, note 72 at 60. **United States:** Medical Research International and the Society of Assisted Reproductive Technology, *supra*, note 74 at 16.

TABLE III: Effects of the Number of Embryos Transferred on Pregnancy

Number of Embryos Transferred	Australia and New Zealand (1979–85)		United Kingdom (1988)		Canada (1984–87)	
	% of clinical pregnancies	% of multiple pregnancies	% of clinical pregnancies	% of multiple pregnancies	% of clinical pregnancies	% of multiple pregnancies
1	—	1	9.6	1	11	0
2	—	12	14.2	13.1	12	11
3	—	33	25.2	29.2	20	20
4	—	30	23.4	24.2	22	15
5	—	13	—	—	24	29

Sources: Canada: Yuzpe *et al.*, *supra*, note 65 at 169. **United Kingdom:** *The Fifth Report of the Interim Licensing Authority for Human In Vitro Fertilisation and Embryology 1990, supra*, note 75 at 24. **Australia and New Zealand:** Paul A. L. Lancaster, "How Many Oocytes/Embryos Should Be Transferred?" (1987) II:8550 Lancet 109 at 110 (letter).

CHAPTER TWO

Issues in Canadian Law

By and large, Canadian law has not adapted easily to the various situations made possible by medically assisted procreation. We will therefore outline in this second chapter the main problems these technologies create for the law. The scope of the task is clearly illustrated by the number of branches of the law and the range of legislation, both federal and provincial, that must be considered. The legal framework within which medically assisted procreation is developing is in fact very broad. It covers such diverse concepts, principles and branches of the law as public policy, parentage, the principle of the non-availability of the human body for commercial purposes,[193] the right to life, the right to liberty, property law, contract law and tort law. In order to identify the legal problems, we will first examine the main rules of law applicable to medically assisted procreation.

I. Medically Assisted Procreation and Private Law

As we will see, a number of rules of private law affect medically assisted procreation. We will look at the rules that govern consent, parentage, successions, contracts, property and liability and their impact on the use of artificial insemination, in vitro fertilization, gamete intrafallopian tube transfer (GIFT) and egg retrieval by uterine lavage. We will consider these rules from the perspective of potential parents, donors, children and medical personnel, because they are the most affected by the legal problems that can arise when medically assisted procreation technologies are used.

A. Potential Parents

1. Consent

The decision to have a child is a private one, normally made within a marriage by both partners. However, medically assisted procreation makes it possible for a woman to conceive a child without her spouse's knowledge; this raises the problem of attributing

193. See *infra* at 41ff.

paternity to a man who is not genetically linked to the child and did not consent to conception.[194] Irrespective of the remedies available to the spouse (separation, divorce, disavowal of paternity),[195] we may consider the need for specific legislative intervention in this area. Should the law make the consent of both spouses a prerequisite for medically assisted procreation?

The problem with such intervention is obvious. Giving a husband the power to decide whether a child should be conceived in effect violates the wife's right to control her own body and her reproductive autonomy.[196]

Currently only Quebec, the Yukon Territory and Newfoundland have provisions dealing with consent to medically assisted procreation, although there is no specific indication of the form of such consent. Article 586 of the *Civil Code of Québec* (*C.C.Q.*) reads as follows:

> When a child has been conceived through artificial insemination, either by the father or, with the *consent* of the spouses, by a third person, no action for disavowal or contestation of paternity is admissible [emphasis added].[197]

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194. We are referring here to cases where gametes from a third person are used, since the spouse's sperm cannot be used without his consent.

195. Michèle Rivet, "Quand la médecine intervient dans la genèse de la conception, que fait le droit? Ou le délicat problème de l'insémination artificielle" in Association Henri Capitant, *Le corps humain et le droit: Journées Belges*, vol. 26 (Paris: Dalloz, 1977) 87 at 95, [TRANSLATION] "Artificial insemination, whether AID or AIH, without the husband's consent does not constitute adultery but is a violation of matrimony that in itself warrants sanction."; Jean-Louis Baudouin, "Aspects juridiques" in Marcel J. Melançon, ed., *L'insémination artificielle thérapeutique* (Quebec: P.U.L., 1983) 113 at 121,

> [TRANSLATION]
> [I]n all systems of law, spouses accept, through the bond of marriage, the obligation to help, assist and be faithful to one another. It is perfectly logical, therefore, to say that AID without the husband's knowledge may be considered a failure to meet that obligation and may become general grounds for divorce or separation as "outrage, ill-usage or grievous insult," "mental cruelty" or "irretrievable damage to the will to maintain the bond of marriage."

196. Requiring the husband's consent is viewed by some as contradicting health legislation. See Bartha Maria Knoppers, *Conception artificielle et responsabilité médicale* (Cowansville, Que.: Yvon Blais, 1986) at 96; in the area of consent to medical treatment or access to medical services, respect for the person's autonomy prevails. Consequently, if one spouse is able to express his or her own wishes, the consent of the other cannot be required before treatment is administered. See also Ellen I. Picard, *Legal Liability of Doctors and Hospitals in Canada*, 2d ed. (Toronto: Carswell, 1984) at 62-63. In Quebec, *An Act respecting health services and social services*, R.S.Q., c. S-5, s. 156, states that: "The consent of the consort shall not be required for the furnishing of services in an establishment." See also arts 19, 19.1 to 19.4 of the *Civil Code of Lower Canada (C.C.L.C.)* and art. 10ff. of Bill 125, *Civil Code of Québec*, 1st Sess., 34th Leg., Quebec, 1990 (1st Reading, 18 December 1990) [hereinafter Bill 125]. In Ontario, see the *Family Law Act, 1986*, S.O. 1986, c. 4, s. 64(2): "A married person has and shall be accorded legal capacity for all purposes and in all respects as if he or she were an unmarried person."

197. Article 580 of Bill 125, *supra*, note 196, reiterates these principles:

> No person may contest the filiation of a child on grounds relating to his medically assisted procreation, and no claim to another status is admissible from the child.
>
> However, the husband of the mother may disavow the child or contest acknowledgement if he did not give consent to medically assisted procreation or if he proves that the child was not born of such procreation.

For the Yukon, see *Children's Act*, R.S.Y.T. 1986, c. 22, s. 13(3)-(5). Subsection 13(3) states: "A man who is married to a woman at the time she is artificially inseminated solely with the semen of another man shall be deemed in law to be the father of the resulting child if he consents in advance to the insemination." For Newfoundland, see *The Children's Law Act*, S.N. 1988, c. 61, s. 12(3).

Some view this provision as requiring the husband's consent. On closer inspection, however, consent here is merely a defence in bar against any action in disavowal of paternity in cases involving parentage, divorce or successions.[198] Therefore, the effect of the provision is not to recognize the husband's authority to decide, but rather to attach consequences to his consent[199] by preventing him from alleging the absence of a biological link to disown a child whose conception he desired. We will come back to this point.

The fact that there are remedies available to the husband[200] and the importance of the woman's right to control her own body and her reproductive autonomy lead the Commission to conclude that the husband's consent should not be required for medically assisted procreation.

It should be noted that the question of consent by both future parents can be considered from another perspective, namely that of the appropriateness of ensuring legal protection of the traditional family unit in which there are two heterosexual parents. Requiring the consent of both future parents would prevent single people and homosexual couples from using medically assisted procreation. Clearly, such intervention would raise important constitutional issues and would have to reflect a societal choice between several fundamental values. It is this fundamental aspect of the question of access to medically assisted procreation that we will examine in detail later.

2. Control over Gametes and Embryos

Infertile individuals or couples who entrust a bank with their gametes or embryos normally intend to retain exclusive control over the way they are used.[201] However, the basis of such control must be examined in terms of the law. Could it be a right of ownership, a right of possession or a contractual relationship (respect for the consent and intentions

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198. The Yukon and the Newfoundland provisions are found in the section entitled "Establishment of Parentage."

199. A similar approach is used in s. 11.2 of *An Act to amend the Uniform Child Status Act*, passed in August 1991, amending the *Uniform Child Status Act* (1980), Uniform Law Conference of Canada, *Consolidation of Uniform Acts* (Fredericton, N.B.: The Conference) Permanent Codification at 5-1:

> 11.2. Notwithstanding section 6(3), for a child born before or after this section comes into force as a result of an assisted conception, a presumption of paternity pursuant to section 9 may be rebutted only by proof that
>
> (a) the presumed father
> (i) is not the genetic father of the child, and
> (ii) did not consent, or before conception withdrew his consent, to be the father of any child born as a result of the assisted conception; or
>
> (b) where the sperm of the presumed father was used in the assisted conception,
> (i) he did not consent, or before conception withdrew his consent, to be the father of any child born as a result of the assisted conception, and
> (ii) the child was not conceived as a result of sexual intercourse between the mother and him.

200. See *supra* at 38.

201. We will examine the donor's situation in the following section. See *infra* at 46ff.

of the producer of the gametes)? Three decisions, one in France in 1984,[202] the other two in the United States in 1988 and 1989 — *Davis*[203] and *York*,[204] — ruled on such matters. We will turn our attention first to gamete storing in light of the French ruling, and then to the fate of embryos in light of the U.S. rulings.

On the subject of gamete storing, a French court was asked to rule in 1984 in the *Parpalaix*[205] case, which involved a dispute between CÉCOS, a centre for sperm analysis and storage, and the widow of a man who had stored sperm at the centre. The centre refused to grant the widow's request to retrieve the sperm so that she could be artificially inseminated. The widow argued that her husband and the centre had signed a contract of deposit.

The judge ruled that in the case in question the agreement was not a contract of deposit but rather an innominate contract under which CÉCOS agreed to store the sperm and return it on request to the producer or, following his death, his heirs. The judge wrote:

> [TRANSLATION]
> The rules of the contract of deposit as defined by article 1915 *et seq.* C.C. cannot be applied in the case at bar, which concerns not *objects of commerce*, but rather a secretion that contains the seed of life and is to be used to produce a human being. . . .
>
> It appears that the agreement of 7 December 1981 was a specific contract under which CÉCOS was obligated to store the sperm and return it to the donor or the woman for whom the sperm was intended [emphasis added].[206]

The court did not go so far, however, as to determine that the husband owned the gametes. Rather, it ordered that the sperm be returned on the basis of the deceased man's intentions and the absence of a stipulation that CÉCOS intended to keep the sperm if the producer died.

The reference by the judge in the case to things that are not objects of commerce needs clarification. In the civil law, things that are not objects of commerce are not subject

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202. Trib. gr. inst. Créteil, 1 August 1984, *Parpalaix* v. *C.É.C.O.S.*, Gaz. Pal. 1984.II.560.

203. *Davis* v. *Davis* (21 September 1989), Blount Cty E-14496 (Cir. Ct) at 1-2; this decision has since been reversed by 59 U.S.L.W. 2205 (Tenn. App. 1990). See *infra*, note 216 for more details.

204. *York* v. *Jones Institute*, 717 F. Supp. 421 (E.D. Va 1989) (order of 10 July 1989 denying defendants' motion to dismiss). See *infra*, note 217, for more details. Note that the United States and Australia have also had to consider this issue in the *Rios* case; *In re Estates of Elsa and Mario Rios* (May 1985), Los Angeles Cty P680682, P680683 (Sup. Ct). The California Superior Court decided not to appoint a guardian for the embryos and ruled that they were neither the heirs nor the property of the Rioses. See George P. Smith, "Australia's Frozen 'Orphan' Embryos: A Medical, Legal and Ethical Dilemma" (1985) 24 J. Fam. L. 27. See also Tamara L. Davis, "Protecting the Cryopreserved Embryo" (1990) 57 Tenn. L. Rev. 507 at 518.

205. *Supra*, note 202. For an interesting analysis of this ruling, see Jones, *supra*, note 147.

206. *Parpalaix*, *supra*, note 202 at 562.

to human will and cannot be disposed of, even gratuitously.[207] The word "commerce," therefore, has a very specific meaning here,

> [TRANSLATION]
> a special meaning more general than its usual one. It refers not only to commercial transactions *per se* . . . but to any legal act the purpose of which is to create, modify or extinguish rights. A thing that is not an object of commerce is a thing that cannot be the object of legal acts performed by individuals. "Commerce" evokes the notion of things circulating among persons, but it is not synonymous with the economic term "market."[208]

This broad definition explains in part why some French authors are sceptical about including the body and its parts and substances among things that are not objects of commerce.[209]

In any event, in Quebec civil law article 20 *C.C.L.C.* permits the *inter vivos* disposal of parts or products of the body,[210] even in return for payment. It may therefore be concluded that, to the extent that article 20 applies to sperm and ova, gametes could be objects of commerce in Quebec civil law.[211]

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207. Marie-Angèle Hermitte, "Le corps hors du commerce, hors du marché" (1988) 33 Arch. philo. dr. 323 at 325.

208. Jean-Christophe Galloux, "Réflexions sur la catégorie des choses hors du commerce: l'exemple des éléments et des produits du corps humain en droit français" (1989) 30:4 C. de D. 1011 at 1015-16.

209. Hermitte, *supra*, note 207 at 327, holds the view that the body itself is an object of commerce. Commenting on s. 1128 of the French Civil Code (equivalent to art. 1059 *C.C.L.C.*), she writes:

> [TRANSLATION]
> It is therefore not the body that is protected in this way, placed beyond the exercise of will by article 1128, but rather the *person*, a legal abstraction defined by attributes, themselves abstract, that are considered to be the framework of human dignity. . . . This illustrates by *reductio as absurdum* that the civil law views the body as nothing more than an incidental medium for representations that centre on the person, defined by changing references to morals, dignity and liberty. Violations of the body are not taken into consideration until they engender a violation of these values.

See also Galloux, *supra*, note 208 at 1019, on the limited scope in French law of the notion of "extracommerciality" as it relates to the products and elements of the human body. Citing as examples blood, mother's milk and gametes, he concludes that [TRANSLATION] "[h]uman products circulate among private or public individuals; they do not, as the status of extracommerciality would require, remain under the exclusive control of the person from whom they come."

210. Jean-Louis Baudouin and Catherine Labrusse-Riou, *Produire l'homme: De quel droit?* (Paris: P.U.F., 1987) at 44: [TRANSLATION] "In Quebec law, the provisions so adopted apply not only to organs themselves, but also body substances (blood, sperm, etc.)." See also arts 19 and 24 of Bill 125, *supra*, note 196. However, art. 25 of the bill drops the distinction between parts of the body that are capable of regeneration and those that are not by requiring that alienation be gratuitous in all cases. Art. 25 reads: "The alienation by a person of a part or product of his body shall be gratuitous; it shall not be repeated if it involves a risk to his health."

211. Baudouin and Labrusse-Riou, *supra*, note 210 at 115: [TRANSLATION] "However, such liberalization is possible only from a therapeutic perspective or at least one of scientific experimentation leading to the development of a treatment."

It follows therefore that article 1059 *C.C.L.C.*, which states that "[t]hose things only which are objects of commerce can become the object of an obligation,"[212] could not impede the creation of rights and obligations between the bank and persons who deposit their gametes.[213] Gametes could thus be the subject-matter of a contract. It should be noted, however, that such freedom of contract would be subject to the criterion set out in article 20(1) (proportionality of risks[214]) and to articles 13 and 990 *C.C.L.C.* (public order and good morals).[215]

The agreement between the bank and the person storing his or her gametes could therefore be used to create rights and obligations for the parties. With respect to the couple, it would be sufficient for each partner to enter into a separate contractual relationship with the bank to have independent control over his or her gametes. This would prevent disputes over the use of one partner's gametes if, for any reason, he or she no longer wished to proceed with the parental plan. However, an additional problem arises with ova. Since freezing of ova seems to pose major difficulties, the normal procedure is to freeze eggs that have been fertilized in vitro (embryos). Once the egg has been fertilized, independent control of the gametes must give way to a form of joint control.

Whether the embryo is produced by the couple or from one or two donated gametes, the question of control is a delicate problem. In case of separation, for example, both spouses may claim the embryos, or one spouse may object to their being used. We must therefore provide for how such disputes can be resolved where no provision has been made in the contract or the consent form signed by the spouses. The U.S. decisions in *Davis* v. *Davis*[216]

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212. See also art. 1058 *C.C.L.C.*

213. In the event of a conflict, the specific prevails over the general provision: Pierre-André Côté, *The Interpretation of Legislation in Canada* (Cowansville, Que: Yvon Blais, 1984) at 240.

214. The risk assumed must not be disproportionate to the benefit anticipated. See art. 20 *C.C.L.C.*, *infra* at 47.

215. Albert Mayrand, *L'inviolabilité de la personne humaine* (Montreal: Wilson & Lafleur, 1975) at 81.

216. *Supra*, note 203. The case centred on the absence of a consent form or document providing for the disposition of the embryos in the event that Mr. and Mrs. Davis divorced. Despite the divorce, Mrs. Davis wanted to use the frozen embryos in the hope of having a child, but Mr. Davis objected on the grounds that he had no intention of becoming a father. Mrs. Davis claimed that the embryos were living and that as a mother she was entitled to use them to try to conceive. She argued that if she were unable to use them herself, the embryos should be given to an infertile couple so that they could be carried to term. The trial judge, W. Dale Young, ruled as follows (*supra*, note 203 at 1-2):

and *York* v. *Jones Institute*[217] bear witness to the problems that can arise and the difficulty in resolving them.

It is to be hoped that the experience gained from these cases will result in more suitable consent forms. In any case, is it possible to make provision in a consent form for the fate of an embryo in the event of a dispute, separation, divorce or death?[218] This leads us

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> The salient findings, conclusions and the judgment are summarized as follows, to-wit: (1) Mr. and Mrs. Davis undertook *in vitro* procedures for the purpose of producing a human being to be their child. (2) The seven cryogenically preserved embryos are human embryos. . . . (5) From fertilization, the cells of a human embryo are differentiated, unique and specialized to the highest degree of distinction. (6) Human embryos are not property. (7) Human life begins at conception. (8) Mr. and Mrs. Davis have produced human beings, *in vitro*, to be known as their child or children. (9) For domestic relations purposes, no public policy prevents the continuing development of the common law as it applies to the seven human beings existing as embryos, *in vitro*, in this domestic relations case. (10) The common law doctrine of *parens patriae* controls children, *in vitro*. (11) It is to the manifest best interests of the child or children, *in vitro*, for their Mother, Mrs. Davis, to be permitted the opportunity to bring them to term through implantation.
>
> . . .
>
> The temporary custody of the seven cryopreserved human embryos is vested in Mrs. Davis for the purpose of implantation. All issues of support, visitation, final custody and related issues are reserved to the Court for consideration and disposition at such time as one or more of the seven human embryos are the product of live birth.

For more details about this case, see John A. Robertson, "Resolving Disputes over Frozen Embryos" (1989) 19:6 Hast. Cent. Rep. 7 at 11.

> Judge Young's conclusion that four-celled preimplantation human embryos are "children" and "human beings" is unprecedented and unwarranted. It has no discernible basis in common law precedents nor in Tennessee law (which recognizes a separate legal interest in prenatal human life only at viability). It is a view rejected by highly respected ethical advisory bodies in the United States, Great Britain, Canada, France, and several other countries. This remarkable conclusion appears to represent the judge's own personal view of the significance of the biological fact that a new human genome exists at or shortly after fertilization.

On appeal from the *Davis* decision (*supra*, note 203 at 2206), the judge ruled:

> The trial court in his fact finding and legal conclusions, ignored the public policy implicit in the Tennessee Statutes, the cases holdings of the Tennessee Supreme Court and the teachings of the United States Supreme Court. We are required to resolve the issue consistent with the existing Tennessee law and the parties' constitutional rights. On the facts of this case, it would be repugnant and offensive to the constitutional principles to order Mary Sue to implant these fertilized ova against her will. It would be equally repugnant to order Junior to bear the psychological, if not the legal consequences of paternity against his will. Jointly, the parties share an interest in the seven fertilized ova.
>
> Accordingly, the cause is remanded to the trial court to enter a judgment vesting Mary Sue and Junior with joint control of the fertilized ova with equal voice over the disposition.

217. *Supra*, note 204. The issue in this case was a couple's right to transfer a frozen embryo from one fertility clinic to another. The consent form signed by Mr. and Mrs. York did not provide for the possibility of a change in physicians.

218. Bernard M. Dickens, "Artificial Reproduction and Child Custody" (1987) 66 Can. Bar Rev. 49 at 65: "A contract could be directed to the rendering of scientific or medical services, including maintenance of an embryo *in vitro* or in cryopreservation, and need not involve concepts of property law."

to question the status of the embryo: Does it fall under the law of property or that of persons? Positive law is unable to answer this question, which is a philosophical, theological and ethical problem: At what point does human life begin?[219]

The question of control over gametes and embryos has been considered from the perspective of property law:

> The elements of use, alienation . . . , disposal and destruction, even when exercised subject to statutory regulation, appear to comprise the power legally contained in the concept of property ownership. According to property principles, it seems that the gamete donors could exercise control over the embryo *extra uterum*, abandon their respective rights of control to the exclusive exercise of the other (as in ordinary artificial insemination by sperm donor), agree upon its transplantation into another woman without invoking adoption law, and rely on property principles in settling disagreements on disposition. In the same way, gamete donors may delegate to clinics and clinic personnel their own authority to decide, for instance, which women may receive transplantations of spare embryos.[220]

However, the nature of the "deposited" product makes such an a approach difficult.[221] Some hold the view that this property right is inconsistent with the traditional

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219. *Biomedical Experimentation Involving Human Subjects*, *supra*, note 7 at 46-47. See also the recent decisions in *Murphy* v. *Dodd* (1989), 70 O.R. (2d) 681 (H.C.J.); *Tremblay* v. *Daigle* (7 July 1989), Abitibi 170-05-000012-898 (Québec Sup. Ct)(interim interlocutory injunction); [1989] R.J.Q. 1980 (Sup. Ct) (interlocutory injunction), appeal dismissed [1989] R.J.Q. 1735 (C.A.), reversed by unanimous decision of the Supreme Court of Canada, [1989] 2 S.C.R. 530. It should be noted, however, that an embryo fertilized in vitro is not covered by the definition of fetus in the working paper *Crimes against the Foetus*, *supra*, note 7 at 50: "the product of a union in the womb of human sperm cells and egg cells at all stages of its life prior to becoming a person."

220. Dickens, *supra*, note 218 at 62-63. And at 64-65: "Destruction or other misappropriation of an object without the owner's consent may constitute the crime of theft, and/or the torts of trespass to property and conversion."

221. Bartha M. Knoppers, "Reproductive Technology and International Mechanisms of Protection of the Human Person" (1987) 32 McGill L. J. 336 at 346:

> [A]ll agree that the embryo *in vitro* constitutes human life worthy of protection . . . while the majority deny the possibility of granting the donor a proprietary interest in human gametes or embryos, most would seem to grant the donor at least some possessory interest, and in some cases, a residual right. . . . Indeed, there is no area where the need for some common international principles of respect and protection is more imperative, if we are truly to distinguish between human genetic material as property, as a simple product of conception or as human life.

Bernard M. Dickens, "The Ectogenetic Human Being: A Problem Child of Our Time" (1980) 18 U.W.O. L. Rev. 241 at 245, "Litigation in the United States arising from hospitals losing or incinerating fetuses their mothers wanted to bury has been framed in terms of causing emotional injury rather than of misappropriating property." The author refers to *Brooks* v. *South Broward Hospital District*, 325 So. 2d 479 (Fla App. 1975) and *Hembree* v. *Hospital Board of Morgan County*, 300 So. 2d 823 (1974). In *Del Zio* v. *Manhattan's Columbia Presbyterian Medical Center* (14 November 1978) 74-3558 (D.S.N.Y.), when a fertilized egg was destroyed, a U.S. Federal Court judge allowed a claim for damages for loss of property to be heard by a jury. However, "[t]he jury rejected the property claim but awarded plaintiffs damages for the emotional distress. Mrs. Del Zio was awarded $50,000 for emotional distress and Mr. Del Zio was awarded $3.00." Lori B. Andrews, "My Body, My Property" (1986) 16:5 Hast. Cent. Rep. 28 at 29ff.

legal interpretation of the concept and that it is rather a right of supervision and control.[222]

In view of this clear gap in the law, several options are possible. One would be to leave it to the courts to adapt current principles of law to gametes and embryos in order to address the problems they create. Alternatively, we could rethink the traditional legal distictions between persons and things in order to deal specifically with these products of the human body.[223] Finally, it might also be appropriate to look into the possibility of adapting, with respect to these substances, the notion of things that are not objects of commerce.[224] This dilemma is not limited to the problem of control over these substances; it also applies to the very legitimacy of donating gametes and embryos and to their commercialization. These issues will be discussed later.

3. Post-Mortem Use of Gametes and Embryos

The issue of the post-mortem use of gametes and embryos brings us back to the question of the right to dispose of them and of their legal status.[225] Does a widow or widower have any rights over the gametes of his or her deceased spouse or any frozen embryos that they have conceived together?

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222. According to Baudouin and Labrusse-Riou, *supra*, note 210 at 45-46,

> [TRANSLATION]
> the donor must be recognized as having not a true property right, but more a right of supervision and control over the use of his or her gametes, a matter which is part of the broader issue of personality rights. For obvious social reasons, however, the donor must not be permitted to exercise this right in the same way as a true property right. A balance must therefore be struck *de lege ferenda* between respect for the consent and intentions of the donor on the one hand and on the other the exercise of this right in a manner that is compatible with the ethical and social requirements of society as a whole.

The term "donor" seems to be used here to designate both a person who makes a deposit and a person who makes an actual donation, that is, who relinquishes the product donated; *ibid.*, [TRANSLATION] "It is difficult to imagine, for example, a *donor* bequeathing a large fortune to his granddaughter on the condition that she be inseminated after his death with the sperm he *deposited* in a bank for this purpose!" [emphasis added]. The Ontario Law Reform Commission writes:

> It was suggested that the fact that a person does not have absolute beneficial ownership of an object does not mean that he or she has no property or other (for example, possessory) interest in it. [Note 224: For example, under certain circumstances, the *Anatomy Act*, R.S.O. 1980, c. 21, permits the possession of corpses by medical schools for dissection and medical education, even though it has been said that a dead body cannot be the subject of a property right.] Accordingly, even if there are some restrictions on a woman's rights respecting her own ova, presumably some type of interest may still be found in her. And, of course, one person's right or interest in genetic material, however that right or interest is characterized, may permit that person to, for example, donate it to a hospital for experimental purposes, or require it to be destroyed notwithstanding the claims of others to use it for such purposes: that right or interest may well be superior to that of anyone else. [OLRC, *supra*, note 2 at 88].

223. See Hermitte, *supra*, note 207.

224. See Galloux, *supra*, note 208.

225. See *supra* at 39 and 43.

As we have seen in the *Parpalaix* case,[226] the French courts have held the storing of sperm to be a specific contract and ordered the sperm to be returned to the widow of the donor, thereby permitting post-mortem insemination. This conclusion, however, could only be reached through a very legalistic interpretation of the dispute, since the judge did not rule specifically on the use of the sperm for post-mortem insemination.

On a more practical level, it is easy to anticipate the serious problems that post-mortem use of gametes and embryos will create in parentage law and the law of successions.[227] In Canada, neither the law of successions nor parentage law recognizes post-mortem procreation. Presumptions of paternity normally use a test of 300 days between the death of the father and the birth of the child.[228] In Ontario, if no one is presumed to be the father under the 300-day test, any person may apply for a declaration of paternity,[229] provided that "both the persons whose relationship is sought to be established are living."[230]

We may therefore question the appropriateness of making provision in Canadian law for the impact of the post-mortem conception of a child on parentage and inheritance rights. But we must first decide if we wish to allow or prohibit the post-mortem use of gametes and embryos in Canadian society.

B. Donors

1. The Legality, Legitimacy and Nature of Gamete and Embryo Donation[231]

The legality of such a donation is linked to the principle of the inviolability of the human body.[232]

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226. *Supra*, note 202.

227. For example, see the *Rios* case, *supra*, note 204.

228. For example, see *Children's Law Reform Act*, R.S.O. 1980, c. 68, s. 8(1) 2nd para., which presumes paternity if "[t]he person was married to the mother of the child by a marriage that was terminated by death ... within 300 days before the birth of the child." In Quebec, art. 574 *C.C.Q.* states that a child born more than 300 days after the death of the biological father is deemed to have been conceived after the father's death; see also art. 523 of Bill 125, *supra*, note 196.

229. See *Children's Law Reform Act*, *supra*, note 228, s. 5(1).

230. *Ibid.*, s. 5(2). Dickens, *supra*, note 221 at 247, "This would bar, of course, both the dead biological father and the unborn child, and appear to leave the fetus not that of the father for the purposes of the perpetuity rule or other property interests." It should be noted, however, that the *Uniform Child Status Act* (*supra*, note 199) provides for an exception to this rule where a presumption of paternity pursuant to s. 9 applies. The presumption of paternity provided for in the event of the death of the child's father indicates no time limit regarding the birth of the child or the death of the husband. See ss 6(6) and 9(a).

231. Legality is used here to mean the compliance of an action or undertaking with the law, while legitimacy refers to the ethical and social criteria that make it desirable to prohibit, allow or simply tolerate such an action or undertaking.

232. In Quebec this principle is established by art. 19 *C.C.L.C.*: "The human person is inviolable. No one may cause harm to the person of another without his consent or without being authorized by law to do so." See also arts 19.1-19.4 *C.C.L.C.* and art. 10ff. of Bill 125, *supra*, note 196.

> Inviolability ... may have two contents of meaning. It may connote that one is not justified in treating another without his consent, but is justified in doing so with it, in which case it is merely a particular application of the autonomy principle; or it may indicate a principle that protects a person's physical and mental integrity against non-beneficial acts by the person himself, or others, when it is a preservation of life value.[233]

This second interpretation of the principle of the inviolability of the human body imposes a limit on what a person can consent to. It is this second aspect that seems to have captured the Quebec legislature's interest when the *Civil Code of Lower Canada* was amended in 1971.[234]

Article 20 *C.C.L.C.* allows competent persons to dispose of parts of their bodies, whether or not the body part is capable of regeneration, subject in both instances to article 19.1 (proportionality of risks) and written consent. Article 20 reads as follows:

> A person of full age may consent in writing to disposal *inter vivos* of a part of his body or submit to an experiment provided that the risk assumed is not disproportionate to the benefit anticipated.
>
> A minor capable of discernment may do likewise with the authorization of a judge of the Superior Court and with the consent of the person having parental authority, provided that no serious risk to his health results therefrom.
>
> The alienation must be gratuitous unless its object is a part of the body susceptible of regeneration.
>
> The consent must be in writing; it may be revoked in the same way.

To the extent that the conditions set out in article 20 are met and gametes are considered parts of the body within the meaning of the article, there is no doubt in Quebec law as to the legality of gamete donation.[235]

In the common law provinces, tissue donation is covered by statutes based on the *Uniform Human Tissue Gift Act*,[236] subsection 3(1) of which reads as follows:

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233. Margaret A. Somerville, *Consent to Medical Care*, study paper prepared for the LRC (Ottawa: Supply and Services Canada, 1980) at 5.

234. See François Heleine, "Le dogme de l'intangibilité du corps humain et ses atteintes normalisées dans le droit des obligations du Québec contemporain" (1976) 36 R. du B. 2 at 10.

235. See Baudouin and Labrusse-Riou, *supra*, note 210 at 44. It should be noted that arts 18-22 of *An Act to add the reformed law of persons, successions and property to the Civil Code of Québec*, S.Q. 1987, c. 18, essentially reiterate art. 20ff. *C.C.L.C.* and add specific requirements and conditions. See Monique Ouellette, "De la jouissance et de l'existence des droits civils et de certains droits de la personnalité" (1988) 1 C.P. du N. 1 at 20. See also arts 19-25 of Bill 125, *supra*, note 196.

236. *Uniform Human Tissue Gift Act*, repealed and replaced by *Uniform Human Tissue Donation Act* (1989), Uniform Law Conference of Canada, *supra*, note 199 at 22-1.

> Any person who has attained the age of majority, is mentally competent to consent, and is able to make a free and informed decision may in a writing signed by him consent to the removal forthwith from his body of the tissue specified in the consent and its implantation in the body of another living person.[237]

Although the *Uniform Human Tissue Gift Act* (UHTGA) does not state that the risk incurred is not to be disproportionate to the anticipated benefit, the common law recognizes this condition.[238] However, unlike the *Civil Code*, the UHTGA excludes tissue capable of regeneration.[239]

Thus, insofar as sperm and even eggs (despite the fact that eggs are limited in number) are parts of the body capable of regeneration,[240] statutory provisions on human tissue

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The Canadian statutes on tissue donation are: *Human Tissue Gift Act*, R.S.A. 1980, c. H-12; *Human Tissue Gift Act*, R.S.B.C. 1979, c. 187; *The Human Tissue Act*, S.M. 1987-88, c. 39; *The Human Tissue Act, 1971*, S.N. 1971, No. 66; *Human Tissue Act*, R.S.N.B. 1973, c. H-12; *Human Tissue Gift Act*, R.S.N.S. 1989, c. 215; *Human Tissue Gift Act*, R.S.O. 1980, c. 210; *Human Tissue Gift Act*, R.S.P.E.I. 1988, c. H-13; *The Human Tissue Gift Act*, R.S.S. 1978, c. H-15; *Human Tissue Act*, R.S.N.W.T. 1988, c. H-6; *Human Tissue Gift Act*, R.S.Y.T. 1986, c. 89; see in particular, for example, the Ontario statute, s. 1(c), and the Alberta statute, s. 1(b).

237. *Supra*, note 236, s. 1(c) defines "tissue" as follows: "'tissue' includes an organ, but does not include any skin, bone, blood, blood constituent or other tissue that is replaceable by natural processes of repair."

238. See Knoppers, *supra*, note 196 at 95-96 n. 149. See also Bernard M. Dickens, "The Control of Living Body Materials" (1977) 27 U.T.L.J. 142 at 165: "The dividing line between permissible and prohibited tissue loss remains a matter of public policy, as judicially determined, but public policy evolves over the course of time, and can be adapted to accommodate biotechnical developments and changing social priorities and recognition of the limits of self-sacrifice." See also, generally, Picard, *supra*, note 196 at 67ff. and at 125ff.; *Hopp* v. *Lepp*, [1980] 2 S.C.R. 192; *Reibl* v. *Hughes* (1977), 16 O.R. (2d) 306 (H.C.J.), rev'd (1978) 21 O.R. (2d) 14 (C.A.), rev'd by [1980] 2 S.C.R. 880. Further, in criminal law, s. 45 of the *Criminal Code*, R.S.C. 1985, c. C-46, provides:

> Every one is protected from criminal responsibility for performing a surgical operation on any person for the benefit of that person if
>
> (*a*) the operation is performed with reasonable care and skill; and
>
> (*b*) it is reasonable to perform the operation, having regard to the state of health of the person at the time the operation is performed and to all circumstances of the case.

See also s. 14 of the *Criminal Code*.

239. *Supra*, note 236. The latest version of the statute, *Uniform Human Tissue Donation Act*, *supra*, note 236, available for adoption by the provinces, provides in s. 1 that "'tissue' means a part of a living or dead human body, but does not include (a) spermatozoa or ova, (b) an embryo or fetus." It remains to be seen whether the provinces will adopt these amendments.

240. See Knoppers, *supra*, note 196 at 109; Heleine, *supra*, note 234 at 61: [TRANSLATION] "[I]n medicine as we know it today, blood, milk, hair, skin, bone marrow and genetic material are considered parts of the body susceptible of regeneration." Commenting on the Ontario statute (*supra*, note 236), the OLRC wrote in its report, *supra*, note 2 at 60:

donation do not apply, and the donation of gametes is governed by the common law: "Under the common law, an adult, if fully informed, can consent to having regenerative tissue removed from his body. Indeed, the Red Cross Blood Transfusion Service is wholly dependent on such donations."[241]

While we may conclude (subject to the ambiguity surrounding the characterization of gametes) that our systems of law seem to cast aside any doubt as to the legality of gamete donations, the legitimacy of such donations is certain to draw comment because of the very nature of gametes.

For some authors, discussions of gamete and embryo donation are too often centred on the controls and conditions that may be imposed, thereby clouding the question of the ethical value of such donations:

> [TRANSLATION]
> Some essential questions concerning the donation of gametes have thus been purely and simply "medicalized" and therefore trivialized. Science has taught us to think that the problems lie not in the ethical value of the actual procedure, but rather, because the procedure is established, in the controls and conditions which may be imposed. Accordingly, the public and jurists have been conditioned to believe that the legitimacy and, consequently, the legality of gamete donation were no longer open to discussion in ethical and legal terms. All that remained was to look to the law for procedural management models. In focusing the debate on the question of "how," we truly lost sight of "why." Science has acted as if the only real problems were technical.[242]

Some hold the view that the question of the legitimacy of gamete donation cannot be settled until an ethical and legal analysis has been conducted of the fundamental issues gamete donation raises for our society. Marie-Angèle Hermitte summarized the question as follows:

> [TRANSLATION]
> We have to decide whether or not we want to be a society that considers kinship to be subject to commercial transactions. . . . To answer the question, we need to determine whether the "transaction" is to be analysed as simply a donation of life or as a shift in the order of consanguinity. The analysis in the first case is materialistic and purely biological: AID is viewed as a somewhat magical treatment for sterility. In the second case, the donation

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> The critical question is, of course, whether the Act applies to the donation of sperm or ova, or, put another way, whether sperm or ova come within the definition of "tissue" in the Act. Section 1(c) provides that "tissue" includes an organ, but does not include any skin, bone, blood, blood constituent or other tissue that is replaceable by natural processes of repair.
> . . .
> There would appear to be little controversy that sperm comes within the closing flush of section 1(c) and, accordingly, is outside the purview of section 3(1). However, the same may not be said of ova. A woman's complement of ova is fixed and not replaceable; she loses one or more during menstruation from puberty to menopause.

241. Picard, *supra*, note 196 at 129. See also Dickens, *supra*, note 238 at 163-64.

242. Baudouin and Labrusse-Riou, *supra*, note 210 at 195.

> of life is part of the logic of genealogy, and one realizes that a branch of the family tree is being broken. In the end, the questions remain the same: Are bodies nothing more than living matter which may be passed on according to the rules of trade? Are they not also the medium for the cultural representations that transcend them, at least in part?[243]

Having briefly analysed the question of gamete donation, we must now turn our attention to embryo donation. Neither the civil nor the common law provides for the donation of embryos. Indeed, it may be difficult to consider embryos as tissues or parts of the body (whether capable of regeneration or not). The ambiguity of the embryo's status gives rise to moral and social objections that have appeared with the creation and freezing of surplus embryos. What is at issue here is one's image of the embryo: Is it a thing, a person, a potential person, or something else? The question of the legitimacy of embryo donation therefore remains completely unanswered. Do we wish to legalize or prohibit embryo donation?

To end this discussion of the legality and legitimacy of gamete and embryo donation, we might ask ourselves in more general terms whether we wish to treat gametes and/or embryos differently from other parts of the body or alienable cells, or in other words, create a special regime suited to the specific nature of gametes and embryos.[244]

In concluding, we should address the question of the very nature of gamete and embryo donation. Are such donations blind or conditional? In other words, are donors entitled to attach conditions to the donation? May they withdraw their consent?

While the donation of tissues and body substances such as blood, milk and bone marrow creates few moral problems, the donation of gametes and embryos, which entails the potential to create a human life, is more problematic. In light of the significance of such donations, the donor may wish to attach conditions to how the gamete or embryo is used. For this reason, gamete and embryo donation should not be permitted without the free and informed consent of the donor, not only regarding the procedure and the risks of donating, but also the ultimate purpose of the donation. It is therefore essential that the donor be told how the donated gametes or embryo will be used.

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243. *Supra*, note 207 at 337.

244. In its working paper on experimentation, the LRC indicated that: "Gametes and human embryos cannot be considered to be simple cells or simple tissues. The first are the virtual sources of new human life; the second already have life." See *Biomedical Experimentation Involving Human Subjects*, *supra*, note 7 at 53.

It would appear that at common law conditions may be attached to donations of organs and tissues that do not regenerate.[245] This is all the more reason why the donation of gametes and embryos should be subject to conditions, provided such conditions are not discriminatory.[246]

The right of a donor to withdraw his or her consent to a donation is provided for in Quebec civil law in article 20 *C.C.L.C.*[247] At common law, such right is determined by the nature of the contract. If the contract is deemed to be a contract for a service, the donor may withdraw his or her consent at any time. However, if the contract is for the sale of a good, the donor would not have the option of withdrawing consent.[248] We might ask whether it is appropriate that the revocable or irrevocable nature of the consent should depend on the nature of the contract (sale of a good or contract for a service). Are not the nature of the donated product and the significance of a donation of life sufficient to warrant the right to revoke a donation of gametes or embryos?

2. Gamete and Embryo Donations: Free and Anonymous

Under current law in the common law provinces, the sale of tissues and parts of the human body is generally prohibited by provisions which deem such sale to be "contrary to public policy."

> No person shall buy, sell or otherwise deal in, directly or indirectly, for a valuable consideration, any tissue for a transplant, or any body or part or parts thereof other than blood or a blood constituent, for therapeutic purposes, medical education or scientific research, and any such dealing is invalid as being contrary to public policy.[249]

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245. *Uniform Human Tissue Gift Act*, *supra*, note 236, s. 3(4): "If for any reason the tissue specified in consent is not removed in the circumstances to which the consent relates, the consent is void." Section 5 provides: "Where a gift under this Part cannot for any reason be used for any of the purposes specified in the consent, the subject matter of the gift and the body to which it belongs shall be dealt with and disposed of as if no consent had been given." See, *e.g.*, the Alberta *Human Tissue Gift Act*, *supra*, note 236, ss 3(4), 8.

246. See Baudouin and Labrusse-Riou, *supra*, note 210 at 45: [TRANSLATION] "A donation of sperm is not a 'blind' donation, but rather a deliberate, directed donation, a conditional donation that is part of a true agreement between the donor, the physician and, through the physician, the recipient or recipients. Donating the potential for human life is not an ethically neutral act and must therefore be evaluated and respected as such."

247. See *supra* at 47. *An Act to add the reformed law of persons, successions and property to the Civil Code of Québec*, *supra*, note 235, art. 21, provides that consent may even be revoked verbally. Art. 24 of Bill 125, *supra*, note 196, provides likewise.

248. OLRC, *supra*, note 2 at 62.

249. See *Uniform Human Tissue Gift Act*, 1971, *supra*, note 236, s. 10. It should be borne in mind that most of the provinces patterned their legislation after this model. Section 10 was amended as follows, omitting the notion of public policy (*Uniform Human Tissue Donation Act*, 1989, *supra*, note 236):

The scope of this prohibition is not entirely clear, however. On the one hand, the definition of "tissue" excludes tissues that are capable of regeneration, which suggests that they are exempt from the prohibition. On the other hand, the language of the provision seems to indicate the intention also to include tissues that are capable of regeneration: "No person shall buy, sell ... *any tissue for a transplant*, or any body or part or parts thereof *other than blood or a blood constituent* [emphasis added]."[250]

In Quebec, article 20 *C.C.L.C.* permits the sale of parts of the body that are capable of regeneration.[251] We may therefore conclude that if gametes are considered as tissues or parts of the body capable of regeneration, donations would not necessarily have to be gratuitous.

However, the nature of gametes leads us to consider the appropriateness of prohibiting all commercialization of gametes,[252] permitting only the reimbursement of expenses[253] and limiting the circulation and storage of gametes to hospitals and non-profit fertility clinics. Similarly, we must consider the need to regulate the import of eggs and sperm. We must also ask the same questions with regard to embryo donation.

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15. (1) No person shall buy, sell or other-wise deal in, directly or indirectly, any tissue, body or body part for the purpose of a transplant or for a therapeutic purpose, medical education or scientific research.

(2) Any dealing in any tissue, body or body part that was lawful before this Act came into force shall continue to be lawful, provided this Act is complied with.

(3) A person who contravenes this section is guilty of an offence and liable on summary conviction to a fine of not more than $100,000 or to imprisonment for not more than 1 year, or to both.

As we saw (*supra*, note 239), the definition of "tissue" in this latest version of the *Uniform Human Tissue Donation Act*, *supra*, note 236, does not include spermatozoa, ova, embryos or fetuses.

250. *Ibid.* For more details on this matter, see the forthcoming LRC working paper *Procurement and Transfer of Human Tissues and Organs*.

251. *An Act to add the reformed law of persons, successions and property to the Civil Code of Québec*, *supra*, note 235, art. 22, provides: "The alienation of a part of the human body not capable of regeneration shall be gratuitous." Therefore, the sale of a part of the body that is capable of regeneration should be permitted. See Ouellette, *supra*, note 235 at 21-22. However, subarticle 22(2), which is new law, prevents exploitation by stating that "[t]he alienation of a part of one's body shall not be repeated if it involves a risk to the health." However, art. 25 of Bill 125, *supra*, note 196, drops the distinction for parts of the body that are capable of regeneration. See *supra*, note 210.

252. See *supra* at 41ff and notes 207 and 208.

253. Section 11.5 of *An Act to amend the Uniform Child Status Act*, *supra*, note 199, provides as follows:

(1) No person shall, directly or indirectly, buy, sell or otherwise deal in human eggs, sperm or embryos.

(2) A person who contravenes this section is guilty of an offence and liable on summary conviction to a fine of not more than $100,000, to imprisonment for not more than one year or to both.

(3) This section does not prohibit a person from giving or receiving reimbursement for reasonable expenses necessarily incurred in donating her own eggs or his own sperm.

Another characteristic of gamete and embryo donation is that it is normally made on the condition, implied or express, that the donor remain anonymous. Donors must therefore be assured adequate protection against disclosure of their identity.

If the donor is considered a "patient," he or she is protected, under both the civil law and the common law, by the rules of confidentiality that normally apply to patient-physician communications. Physicians have always been required, either by medical ethics or by the law, not to disclose the medical information in their patients' records.[254] "It is clear law that a physician owes a duty of confidence to his or her patient. This duty is recognized at common law, in at least two provinces by legislation and may even be constitutionally guaranteed."[255]

The two legal systems also share a rule whereby information may not be disclosed unless the patient gives his or her consent, or unless disclosure is required by law[256] or as a matter of public policy.[257]

Confidential information may also be disclosed in a court of law. However, the risk of such disclosure seems to be greater at common law because physicians do not enjoy any privileges as witnesses,[258] whereas in the civil law a physician is bound to maintain confidentiality in a legal proceeding unless the patient releases him or her from that duty.[259]

Given the special status of donors,[260] we might ask whether it is appropriate to make them subject to the same legal scheme that applies to patients. Moreover, since gamete and embryo donations are made within the very specific framework of medically assisted

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254. Rule 6 of the Canadian Medical Association, *Code of Ethics* (Ottawa: The Association, 1990) reads: "An Ethical Physician: . . . 6. will keep in confidence information derived from a patient or from a colleague regarding a patient, and divulge it only with the permission of the patient except when otherwise required by law."

255. Donald G. Casswell, "Disclosure by a Physician of AIDS-related Patient Information: An Ethical and Legal Dilemma" (1989) 68 Can. Bar Rev. 225 at 228 n. 12. With respect to the common law, this author refers to the following decisions: *A.B.* v. *C.D.* (1851), 14 Dunlop's S.C. 177 (C. Sess., Scot.); *Furniss* v. *Fitchett*, [1958] 77 N.Z.L.R. 396 at 400 (S.C.); *Halls* v. *Mitchell*, [1928] S.C.R. 125 at 136; *Re Inquiry into Confidentiality of Health Records in Ontario* (1979), 24 O.R. (2d) 545 (C.A.), rev'd (*sub nom. Solicitor General of Canada* v. *Royal Commission of Inquiry into Confidentiality of Health Records in Ontario*), [1981] 2 S.C.R. 494 at 500-01. For Quebec, the author refers to the *Charter of Human Rights and Freedoms*, R.S.Q., c. C-12, ss 5 and 9; the *Medical Act*, R.S.Q., c. M-9, s. 42; and the *Code of Ethics of Physicians*, R.R.Q. 1981, c. M-9, r. 4, s. 3.01.

256. Picard, *supra*, note 196 at 17-19; Gilbert Sharpe, *The Law and Medicine in Canada*, 2d ed. (Toronto: Butterworths, 1987) at 184-91.

257. Casswell, *supra*, note 255 at 231.

258. Knoppers, *supra*, note 196 at 125; see also *Halls* v. *Mitchell*, *supra*, note 255 at 136.

259. See *Medical Act*, *supra*, note 255, s. 42, and s. 9 of the Quebec Charter.

260. There is uncertainty both in Quebec and in the common law provinces about considering donors as patients. See the OLRC report, *supra*, note 2 at 83; and Bartha Maria Knoppers, "Vérité et information de la personne" (1987) 18 R.G.D. 819 at 830.

procreation, we cannot ignore the need for information of the other persons involved.[261] In light of these factors, it may be reasonable to consider the establishment of another scheme that would protect the donor's privacy and at the same time guarantee access to the medical, genetic and social information required by the other persons involved.

3. Donor Consent

As stated earlier,[262] because the human body is inviolable, the donation of sperm, ova and embryos requires the free and informed consent of the donor. In Quebec, article 20 *C.C.L.C.* states that such consent must be in writing. The same requirement exists in the other provinces that adopted section 3 of the *Uniform Human Tissue Gift Act*.[263] Further, in both civil and common law the risk incurred must not be disproportionate to the anticipated benefit.

Ovum donation, however, poses a special problem. In cases where consent was given for a procedure requiring egg retrieval (for any reason), it is not certain under the law as it now stands whether it is necessary to obtain the woman's consent to dispose of her eggs if she does not specify the purpose for which they are intended:

> Ova may be obtained ... for instance at a woman's sterilization, investigation for subfertility, or hysterectomy. Further, where superovulation is stimulated to assist a woman to become pregnant by I.V.F., any surplus ova may be available to others. ... It is not clear, however, that such sources of ova for I.V.F. of other women are legally required to give consent. If they take initiatives to control recovered ova, their wishes must be respected.[264]

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261. See *infra* at 157-60.

262. See *supra* at 46ff.

263. *Supra*, note 236. It should be noted, however, that the latest version of the Act available for adoption by the provinces does not require written consent. See *Uniform Human Tissue Donation Act*, *supra*, note 236, s. 5(1).

264. Bernard M. Dickens, "Reproduction Law and Medical Consent" (1985) 35 U.T.L.J. 255 at 283, refers to *Venner* v. *Maryland*, 354 A. 2d 483 at 499 (1976), in which the court ruled that "when a person does nothing and says nothing to indicate an intent to assert his right of ownership, possession, or control over such material, the only rational inference is that he intends to abandon the material."

See also OLRC, *supra*, note 2 at 89:

> Assuming that a property right or a right of possession rests in the producer of the human genetic material — and, therefore, assuming that such rights in the material do not automatically pass to the hospital or physician storing or working with it — questions still arise concerning, for example, whether these rights may be lost merely by a failure to assert them or whether, notwithstanding the absence of specific directions, the producer of the ova or semen may correctly assume that the hospital or physician is under a legal duty to destroy the unused material, with perhaps some routine examination by a pathologist, but not experimentation.

Despite the existence of more general consent, the special nature of ova and the significance of the donation for the woman should justify the need for specific donor consent.

Consent to embryo donation raises other problems. Whether the embryo is derived from the gametes of the two spouses or was conceived using gametes from only one of the spouses and a donor, we may ask whose consent is required.[265] Finally, as discussed earlier,[266] the revocability of consent respecting a donation raises a number of issues for the common law provinces.

4. Donor Liability

A donor who provides false information or fails to disclose information about his or her medical history can endanger the child and the mother. If the donor conceals the fact that he or she carries a genetically transmissible disease and the child born using the gametes he or she donated is affected, the donor may beld liable. The donor would thus have a duty to disclose.

But who would be able to take action against the donor? In the civil law, [TRANSLATION] "a child that is conceived but not yet born enjoys some legal recognition, conditional on its birth."[267] At common law, an action for "wrongful birth" is also open to the parents and the child.[268]

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265. Knoppers, *supra*, note 196 at 99-100.

266. See *supra* at 51.

267. Baudouin and Labrusse-Riou, *supra*, note 210 at 57; Michèle Rivet, "Le droit à la vie ou 'l'hominisation' du XXIe siècle: l'éthique et le droit répondent à la science" in Daniel Turp and Gérald A. Beaudoin, eds, *Perspectives canadiennes et européennes des droits de la personne* (Cowansville, Que.: Yvon Blais, 1986) 445 at 457; Bartha Maria Knoppers, "Modern Birth Technology and Human Rights" (1985) 33 Am. J. Comp. L. 1 at 16-17; Edward W. Keyserlingk, *The Unborn Child's Right to Prenatal Care: A Comparative Law Perspective* (Montreal: Quebec Research Centre of Private and Comparative Law, 1984) at 57-59.

268. Baudouin and Labrusse-Riou, *supra*, note 210 at 57; Knoppers, *supra*, note 267 at 16-17:

> The protection of the unborn from negligent injury under the common law was first established with regard to its proprietary and successoral interests from conception onwards, provided the child was born alive. . . . Similarly, the common law in the United States and Canada has either adopted the notion of a pre-existing duty not to harm, or a conditional prospective duty, which crystallizes at birth as the basis for tortious liability. Another recent common law notion is the causal approach, which separates the concepts of injury and damage and looks simply at the causal link between the infant's condition at birth and the defendant's wrongful conduct, thus avoiding the issue of legal personality and the moment of injury altogether.

However, donor anonymity, evidentiary problems and the difficulty of establishing a causal link would make such legal action virtually impossible.[269] Moreover, a liability suit could more easily be taken against the gamete and embryo bank for its failure in the selection and screening phases, or against the physician in charge.

Nevertheless, it should be noted that there is a public-order dimension to donor liability.[270] A donor could be held criminally liable if, for example, he knew he was carrying a potentially fatal virus, still donated his sperm and deliberately withheld the information. It is therefore important that donors at least be identifiable and that their identity be revealed in the event of criminal prosecution for failure to disclose information.

C. Children

1. Legal Parentage

Parentage law organizes the legal relationships between a child and his mother and father.[271] Parentage gives rise to certain rights and obligations, such as the obligation of

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Dickens, *supra*, note 221 at 262:

> Liability for pre-conception torts has recently been recognized under Common Law reasoning, so it may not matter whether the ovum was fertilized or unfertilized when damage occurred. Recognition of pre-conception torts has emerged only recently, however, and upon the basis of United States decisions, so that their status in Canada is at present unavoidably unclear.

See *Jorgensen* v. *Meade Johnson Laboratories, Inc.*, 483 F. 2d 237 at 240 (1973), in which Judge Holloway ruled:

> If the view prevailed that tortious conduct occurring prior to conception is not actionable in behalf of an infant ultimately injured by the wrong, then an infant suffering personal injury from a defective food product, manufactured before his conception, would be without remedy. Such reasoning runs counter to the various principles of recovery which Oklahoma recognizes for those ultimately suffering injuries proximately caused by a defective product or instrumentality manufactured and placed on the market by the defendant. . . .
>
> We are persuaded that the Oklahoma courts would treat the problem of the injuries alleged here as one of causation and proximate cause, to be determined by competent medical proof. . . . And such treatment of the problem would accord with the predominant view that an action may be maintained for prenatal injuries negligently inflicted if the injured child is born alive.

See also *Renslow* v. *Mennonite Hospital*, 351 N.E. 2d 870 (1976).

269. Bartha M. Knoppers and Elizabeth Sloss, "Recent Developments: Legislative Reforms in Reproductive Technology" (1986) 18 Ottawa L. Rev. 663 at 687-88.

270. *R.* v. *Thornton* (15 June 1989), Ottawa-Carleton 1814 (Ont. Dist. Ct), aff'd (1991) 1 O.R. (3d) 480 (C.A.). This very recent ruling by the Ottawa District Court found an individual guilty of public nuisance because he voluntarily donated his blood to the Red Cross even though he knew he was carrying the AIDS virus.

271. Mireille D.-Castelli, *Précis du droit de la famille* (Quebec: P.U.L., 1987) at 119.

parents to feed, care for and educate their children. Legal parentage also has an impact on the law of successions. The legal bond can be established by the biological link (parentage by blood) or by an act of will (adoption). How then is the parentage of children born as a result of medically assisted procreation to be determined?

Traditionally, the establishment of maternal filiation throught the fact of childbirth[272] reflected a biological and genetic certainty. Marriage, a social reality, made it possible to resolve the uncertainty of paternity by a presumption which, while favouring the social aspect of paternity, usually reflected a biological reality.

Some legislatures have over the years eased the traditional rules governing filiation by abolishing the distinction between illegitimate children and legitimate children[273] and recognizing the predominance of biological truth.

In the common law provinces, however, there appears to be disparity between those that establish parentage solely on the basis of marriage and those that have passed laws to ease this common law rule by abolishing the difference between illegitimate and legitimate children.[274]

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272. *Ibid.* With respect to the common law, see Dickens, *supra*, note 218 at 69-70, and Knoppers, *supra*, note 221 at 339-40. This traditional view in Canadian law is expressed by the maxim *Mater est quam gestatio demonstrat.* John K. Mason and Robert A. McCall-Smith, *Law and Medical Ethics*, 2d ed.(London: Butterworths, 1987) at 47.

273. With respect to the civil law see D.-Castelli, *supra*, note 271 at 122; with respect to the common law see Margo Wilson, "Impact of the Uncertainty of Paternity on Family Law" (1987) 45 U.T. Fac. L. Rev. 216 at 232. See *infra*, note 283.

274. *Canadian Family Law Guide* (Don Mills, Ont.: Commerce Clearing House Canadian, 1989) at 2401, para. 4305; see *infra*, note 283. A decision in British Columbia, *Gartrell* v. *Carlsen* (1987), 13 B.C.L.R. (2d) 56 (Prov. Ct), states: "The enactment of subsection 56(1) of British Columbia's *Law and Equity Act* had the effect of making biological parenthood the only kind known to provincial law, and of abolishing the presumption of legitimacy."

Subsection 56(1) of the *Law and Equity Act*, R.S.B.C. 1979, c. 224, as am. S.B.C. 1985, c. 68, s. 80, reads:

> Subject to the *Adoption Act* and *Family Relations Act*, for all purposes of the law of British Columbia,
>
> (*a*) a person is the child of his natural parents,
> (*b*) any distinction between the status of a child born inside marriage and a child born outside marriage is abolished, and
> (*c*) the relationship of parent and child and kindred relationships flowing from that relationship shall be determined in accordance with this subsection.

It should be noted, however, that these changes have sparked controversy, both in Quebec and in the common law provinces, regarding the priority to be given to the various means of proving parentage.[275]

It is questionable whether the legislatures truly intended to choose between the biological and social aspects of parentage. Indeed, whether they established the certainty of maternity and the presumption of paternity or did away with the difference between legitimate and illegitimate children, was their objective to preserve the child's interest, or were they more concerned about ensuring a clearer application of the law (better administration of justice)?

While it is as difficult to determine what the current rules on parentage should reflect (social likelihood or biological truth) as it is to identify legislative intent, applying and adapting the rules to medically assisted procreation is becoming especially problematic. Problems that may arise include: the attribution of the responsibilities of fatherhood to a husband who did not consent to the conception of the child (or to a donor who had absolutely no intention of being a father[276]; disavowal of a child originally wanted[277] by

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This suggests that in the provinces where this traditional distinction has been abolished, the law would still conceal the biological truth under the presumption of legitimacy related to marriage and would thus favour a social truth. However, the British Columbia Supreme Court ruled as follows in *B. (B.J.)* v. *K. (J.)* (1989), 56 D.L.R. (4th) 150 at 158:

> While it is correct to say that s. 56 of the *Law and Equity Act* has, by abolishing "any distinction between the status of a child born inside marriage and a child born outside marriage" abolished the *status* of illegitimacy ... it certainly has not abolished the reality of what we know as "legitimacy" and "illegitimacy". ...
>
> In my opinion, it would require a clear and unambiguous expression of intention by the legislature to displace such a longstanding presumption, which, in my view, provides a just and useful rule. ...
>
> As no such clear and unambiguous expression appears in s. 56 of the *Law and Equity Act*, I hold that the presumption of legitimacy remains in effect in British Columbia.

275. For Quebec, see Jean Pineau, *La Famille* (Montreal: P.U.M., 1982) at 198-202; Michèle Rivet, "La vérité et le statut juridique de la personne en droit québécois" (1987) 18 R.G.D. 843 at 848: the author refers to *Trudeau* v. *Arial*, [1981] S.C. 727, *Droit de la famille-6* (2 December 1982), Québec 200-09-000070-802, J.E. 83-76 (C.A.). Knoppers, *supra*, note 260 at 829, clearly illustrates the ambivalence of the Civil Code on this matter. For the common law position, see *supra*, note 274, and the report of the OLRC, *supra*, note 2 at 64-78.

276. See, *e.g.*, s. 56(1)(*a*) of the *Law and Equity Act*, *supra*, note 274.

277. Subject to art. 586 *C.C.Q.* in Quebec; s. 13(3) of the *Children's Act*, *supra*, note 197, in the Yukon; and s. 12(3) of *The Children's Law Act*, *supra*, note 197, in Newfoundland.

parents who change their mind at some point during the procedure; and the possibility of a challenge of paternity by third parties or the donor and a claim of paternity by the donor.[278]

Application of the current rules governing parentage to technologies that use donated ova has had the effect, for the first time, of dividing maternal biological filiation into genetic filiation and gestational filiation. This situation has faced lawmakers with a choice that they could not have foreseen: Should gestation and delivery prevail over genetic link?

2. Biological Parentage

Children may wish to trace their origin, either to obtain the medical histories of their forebears or to satisfy a psychological need to establish their identity. We can safely say that a child's interest in knowing about his or her medical and genetic history meets with little objection in our society.[279] In practice, however, access to such information is not guaranteed:

> A major inadequacy of present legislative regimes is that, even when they accommodate the preferences of active participants in artificial insemination, as in the case of A.I.D. [artificial insemination with donor], they do not necessarily protect the children consequently

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278. See Dickens, *supra*, note 218 at 68; Canadian Bar Association, *Report of the Special Task Force Committee on Reproductive Technology of the British Columbia Branch*, 1989 at 13 [unpublished]. See arts 586 and 588 *C.C.Q.* and art. 580 of Bill 125, *supra*, note 196. The Yukon has provided for the absence of a legal relationship between a donor and a child born of the product of the donation if the donor is not the husband of the mother: *Children's Act*, *supra*, note 197, s. 13(6). In *An Act to amend the Uniform Child Status Act*, *supra*, note 199, s. 11.4(2) provides that: "A man whose sperm is used in an assisted conception and who is not presumed to be the father of a child pursuant to section 9 is deemed not to be the father of the child."

Art. 579 of Bill 125, *supra*, note 196, is similar:

> Participation in the parental project of another person by way of a contribution of genetic material to medically assisted procreation does not allow the creation of any bond of filiation between the contributor and the child born of that procreation.

279. Baudouin and Labrusse-Riou, *supra*, note 210 at 55; and Bernard M. Dickens, "Legislating for the Brave New Children" in Barbara Landau, ed., *Children's Rights in the Practice of Family Law* (Toronto: Carswell, 1986) 345 at 347. To ensure that records are kept on the genetic origin of children born as a result of medically assisted procreation and that access to those records is made possible, s. 11.6 of *An Act to amend the Uniform Child Status Act*, *supra*, note 199, provides that:

> born. . . . A larger problem concerns children born of donated sperm and/or ova, whose medical care and later reproductive counselling may be dependent upon knowledge of their genetic parentage. The absence of means of tracing at least genetic profiles of biological parents may place them at a disadvantage and perhaps at risk. The adoption model may expose children to disadvantage, but it usually permits discovery of at least a birth mother's characteristics; the practice of birth through donated sperm or ova reveals a default of legislative attention that exposes an increasing number of children to the risk of grave disadvantage to health.[280]

Further, access to this information, assuming it were available, raises the problem of disclosure of the use of a donation from a third party to the conception. We therefore have to decide whether such disclosure should be left to the parents' discretion or whether the child should be recognized as having a right to the information upon reaching the age of majority.

The notion of the child wanting information because of a psychological need to establish his or her identity is not unfamiliar. It is being recognized more and more in the context of adoption. Systems have been put into place to enable adopted children to search for

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> (1) Every duly qualified medical practitioner who carries out procedures that are intended to result in an assisted conception shall maintain, in the form and manner prescribed in the regulations, records indicating the donor and recipient of every egg or sperm used in the assisted conception procedures.
>
> (2) Every duly qualified medical practitioner who carries out procedures that are intended to result in assisted conceptions shall submit information within the knowledge of the practitioner with respect to
>
> (a) assisted conceptions that result from procedures carried out by the practitioner,
>
> (b) births resulting from assisted conceptions that result from procedures carried out by the practitioner, and
>
> (c) procedures carried out by the practitioner that are intended to result in assisted conception, where the practitioner does not know whether conception was or was not achieved.
>
> (3) Every duly qualified medical practitioner shall submit information within the knowledge of the practitioner with respect to births of children delivered by the practitioner that result from assisted conceptions.
>
> (4) The information mentioned in subsection (2) or (3) is to be submitted to the agency designated in the regulations in the form and manner and at the times prescribed in the regulations.
>
> (5) The agency that receives information pursuant to subsection (4)
>
> (a) shall maintain a permanent registry of the information, and
>
> (b) shall not disclose or communicate the information except in accordance with the terms and conditions prescribed in the regulations.
>
> (6) The Lieutenant Governor in Council [or other regulation making authority in the jurisdiction] may make regulations prescribing any matter or thing that is required or authorized by this section to be prescribed in the regulations.

280. Dickens, *supra*, note 279 at 355; see also Knoppers, *supra*, note 267 at 15 n. 64.

their biological parents.[281] In the area of medically assisted procreation, however, because of the confusion over record keeping and the "protection" afforded the donor's anonymity, children are generally denied the right to know about their origins.[282]

We must first ask whether it is appropriate to compare the situation of children born as a result of a donation with that of adopted children and then question the appropriateness of granting them the right to know about their origins or certain rights to information. In any event, it is important to find a middle ground so that the privacy of the donor and the parents is protected. Should no formal right to information be granted, we would anticipate cases in which anonymity might be lifted.

3. Legal Status

Most provinces and territories in Canada have done away with the distinction between legitimate and illegitimate children,[283] but some, such as Alberta and Nova Scotia, have not.

In these provinces, children conceived by use of donated gametes or embryos will be denied the benefits enjoyed by legitimate children, not only in cases where the parents are not married, but also in cases where it is proved that the child was conceived as a

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281. In Quebec, *e.g.*, a summary of the child's history may be delivered upon request to an adoptive parent or to the child if he or she is aged 14 years or older, provided anonymity is respected (*Youth Protection Act*, R.S.Q., c. P-34.1, ss 131.1 and 131.2). Further, the legislature has provided for the reunion of biological parents and adoptees who have reached the age of majority (art. 632 *C.C.Q.*). The search takes into account the intentions of the parties. See, *e.g.*, art. 632 *C.C.Q.* (reiterated in art. 577 of Bill 125, *supra*, note 196) and, in Ontario, Ministry of Community and Social Services, *Adoption Disclosure Services* (Toronto: Queen's Printer for Ontario, 1987). It should be noted, however, that in Quebec, art. 583 of Bill 125, *supra*, note 196, provides for the confidentiality of identifying information about those involved in the medically assisted procreation of a child. An exception is made where confidentiality could cause grave injury to the child's health.

282. According to a study in the United States, barely one-third of the physicians interviewed kept permanent records on children conceived by artificial insemination, and fewer than one-third kept permanent records on donors. See Martin Curie-Cohen, Lesleigh Luttrell and Sander Shapiro, "Current Practice of Artificial Insemination by Donor in the United States" (1979) 300:11 New Engl. J. Med. 585 at 588, quoted in Ann T. Lamport, "The Genetics of Secrecy in Adoption, Artificial Insemination, and *In Vitro* Fertilization" (1988) 14:1 Am. J. L. Med. 109 at 116-17, particularly at 118: "Often the semen used in artificial insemination is collected by a urologist and the insemination [is] done by an obstetrician who may not actually deliver the child."

283. The *Civil Code of Québec* has removed the existing inequities between the different known types of filiation: legitimate, natural and adulterine. See art. 594 *C.C.Q.* (reiterated in art. 536 of Bill 125, *supra*, note 196). See also *Law and Equity Act* (B.C.), *supra*, note 274, s. 56(1); *Child Status Act*, R.S.P.E.I. 1988, c. C-6, s. 1(1) and (4); *Family Services Act*, S.N.B. 1980, c. F-2.2, s. 96(1) and (4); *The Family Maintenance Act*, R.S.M. 1987, c. F20, s. 17; *Children's Law Reform Act* (Ont.), *supra*, note 228, ss 1(1) and (4) and 2(1); *Judicature Act*, R.S.N.W.T. 1988, c. J-1; *Children's Act* (Yukon), *supra*, note 197, s. 5(1) and (4); *The Children's Law Act* (Nfld), *supra*, note 197, s. 3; *The Children's Law Act*, S.S. 1990, c. C-8.1, s. 40; and *Uniform Child Status Act*, *supra*, note 199, s. 2.

result of a donation[284] (despite the fact that artificial insemination with donor is no longer considered adultery). Even though the presumption of paternity covers AID by making the husband the father of the child, there are questions to be asked regarding the appropriateness of clarifying the legal status of children born as a result of gamete or embryo donation:

> [W]here the distinction exists between legitimacy and illegitimacy, the children of proven A.I.D. [artificial insemination with donor] are held to be illegitimate, with all of the legal disadvantages they bear in their social families due to that status. The fact of A.I.D. is frequently concealed, because children born to married women are legally presumed to be their husbands', and no one has an interest to rebut that presumption.[285]

D. Medical Personnel

1. Liability of Physicians

A physician incurs liability when he or she acts in a negligent manner in administering treatment. However, physicians are held only to an obligation of means — or general duty of prudence and diligence —, not to an obligation of result — or absolute duty.[286]

In medically assisted procreation, negligence on the part of the physician may occur before or after conception. Negligence may pertain to the administration of the procedure used, the performance of the duty to inform[287] or the respect of the duty of confidentiality.[288] For the purposes of our study, we will look specifically at the duty to inform, which stems from the duty of every physician to obtain the free and informed consent of his or her patient.[289]

The scope of this obligation to inform appears to vary depending on whether the treatment is therapeutic, elective or experimental. Although the Supreme Court[290] did not

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284. Bartha Maria Knoppers, "Women and the Reproductive Technologies" [1985] Fam. L. Can. 211 at 220; there is always the possibility of an application for legitimation: *Legitimacy Act*, R.S.A. 1980, c. L-11; *Family Maintenance Act*, R.S.N.S. 1989, c. 160, s. 49.

285. Dickens, *supra*, note 279 at 347.

286. Baudouin and Labrusse-Riou, *supra*, note 210 at 57.

287. *Ibid.*; Picard, *supra*, note 196 at 67ff.

288. Baudouin and Labrusse-Riou, *supra*, note 210 at 58; Sharpe, *supra*, note 256 at 181ff. This matter has already been discussed; see *supra* at 53.

289. The requirement of consent flows from application of the rule, protected by the civil law, the common law and the criminal law, that a person's physical integrity may not be violated without the person's consent. With respect to the criminal law, see LRC, *Recodifying Criminal Law: Revised and Enlarged Edition of Report 30*, Report 31 (Ottawa: The Commission, 1987) at 61.

290. Picard, *supra*, note 196 at 92.

comment specifically in *Reibl* v. *Hughes* or *Hopp* v. *Lepp*[291] on the scope of the duty to inform in cases of elective surgery, other decisions, both in the civil law and the common law, interpret the obligation more broadly.[292]

In the field of research, the obligation to disclose information and risks would be even stricter. "Not only must the research subject consent but his or her consent must be explicit and based on what might well be called a 'perfect' disclosure."[293]

The problem in medically assisted procreation is determining whether the different technologies that are used are therapeutic, elective or experimental treatments and, consequently, what standard of disclosure should be required.

Although it is not within the scope of our study to decide this matter, we feel it would be desirable for our courts, in considering this issue, to take into account the specific characteristics of each technology (risks, success rates, and so on).[294]

2. Liability of Gamete and Embryo Banks

Donor selection is vital because it not only increases the chances of success, but also protects the health of the person receiving the donation and prevents the transmission of serious infectious or genetic diseases.[295] Since it was discovered that the AIDS virus can be transmitted through sperm, physicians have begun using frozen sperm for insemination.

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291. *Supra*, note 238.

292. With respect to the common law, see Picard, *supra*, note 196 at 93:

> In interpreting the Supreme Court of Canada's decision in *Reibl* v. *Hughes* [*supra*, note 238], the provincial courts have said that for an elective procedure, minimal or possible risks and alternative procedures and their comparative risks must be explained voluntarily. . . . There is authority for requiring a doctor effecting a sterilization to explain other methods or techniques. It would seem that this can be generalized to cover any elective procedure.

With respect to the civil law, see *Blais* v. *Dion* (27 September 1985), Montréal 500-05-008454-835, J.E. 85-934 at 11 (Sup. Ct); *Dulude* v. *Gaudette*, [1974] C.S. 618 at 621; *Hamelin Hankins* v. *Papillon*, [1980] C.S. 879 at 881. On the current controversy over the risks to be disclosed in cases of plastic surgery, see Louise Potvin, *L'obligation de renseignement du médecin* (Cowansville, Que: Yvon Blais, 1984) at 29-31.

293. Picard, *supra*, note 196 at 118. See also *Biomedical Experimentation Involving Human Subjects*, *supra*, note 7 at 30ff. In Canada, the decision in *Halushka* v. *University of Saskatchewan* (1965), 53 D.L.R. (2d) 436 (Sask C.A.), set the standard and scope of the duty to disclose in the area of experimentation. See at 444: "The subject of medical experimentation is entitled to a full and frank disclosure of all the facts, probabilities and opinions which a reasonable man might be expected to consider before giving his consent. . . . There can be no exceptions to the ordinary requirements of disclosure in the case of research as there may well be in ordinary medical practice."

See also the recent decision by the Quebec Superior Court in *Weiss* v. *Solomon*, [1989] R.J.Q. 731.

294. See chap. 1.

295. Lori B. Andrews, *Medical Genetics: A Legal Frontier* (Chicago: American Bar Foundation, 1987) at 168: "[S]ome women who have been inseminated with donor sperm have contracted venereal disease from the sperm. In addition, children have been born with genetic defects that were passed on by the sperm donor."

Gamete and embryo banks may be liable if they are negligent in screening for genetic defects and diseases. In the civil law, "the laboratory is held to an obligation of result and in the case of error will have to exculpate itself by demonstrating some external force or event."[296] In the common law, "since the standard of care is proportionate to the risks involved, the standard of care could very well be the same."[297]

Unlike donations of other human products, such as blood,[298] the donation of gametes and embryos is not currently subject to any national regulatory scheme. In 1977, an advisory committee examined the question of the storage and use of human sperm; in 1981, the committee submitted a report to the Minister of National Health and Welfare. One of the committee's recommendations was that "[f]ederal regulations governing standards for the acquisition, preservation and importation of human sperm be established."[299] In 1988, the Canadian Fertility and Andrology Society adopted guidelines dealing, among other things, with the selection of donors and genetic screening. However, as stated in the preface, the document was "not intended to be exhaustive, nor to replace any other guidelines or be considered as a rigid set of procedures and standards."[300]

The author refers to William G. Johnson, Robin C. Schwartz and Abe M. Chutorian, "Artificial Insemination by Donors: The Need for Genetic Screening" (1981) 304:13 New Engl. J. Med. 755; David N. Shapiro and Raymond J. Hutchinson, "Familial Histiocytosis in Offspring of Two Pregnancies after Artificial Insemination" (1981) 304:13 New Engl. J. Med. 757. See also *supra*, chap. 1.

296. Knoppers, *supra*, note 267 at 10 n. 47.

297. *Ibid.*

298. The *Food and Drugs Act*, R.S.C. 1985, c. F-27 and the *Food and Drug Regulations* (C.R.C. 1978, c. 870) have set standards respecting, *inter alia*, advertising, labeling, sale, import, processing, storage and the number of donations permitted. The Canadian Red Cross Society also has standards respecting some of these subjects; see *Procurement and Transfer of Human Tissues and Organs*, *supra*, note 250.

299. *Report on Human Sperm 1981*, *supra*, note 148 at xii.

300. Canadian Fertility and Andrology Society, *supra*, note 11 at 3; current practice is therefore fraught with uncertainty respecting the application of uniform criteria. The OLRC wrote in 1985:

> Practices respecting donor screening appear to vary considerably. The most common tests, which are either given by the doctors or required by them to be done in a laboratory, are blood group and type, semen analysis and culture, and VDRL [Venereal Disease Research Laboratory]. Less frequent tests are CBC [Complete Blood Count] and hepatitis, with still fewer responses reporting karotype [sic], genetic screening, and the taking of a family or general history of the donor. Other tests were listed by some practitioners.

The rapid development of medicine makes it difficult to regulate medical selection and the prescription of genetic screening tests. On the other hand, the tremendous uncertainty regarding the uniform application of selection criteria and storage and import standards poses a risk for the unborn child and the future parents. It is therefore important to determine who should be responsible for ensuring the uniformity of the standards used and how this should be carried out. Could the medical profession alone take on this task?

We should also point out that gamete and embryo banks have a duty to respect the donor's consent and may be held liable if they show negligence in the storage of gametes and embryos.

We have seen that many rules of law apply to medically assisted procreation, but in general few are adapted to this new reality. In the chapter listing our recommendations, we will endeavour to address the problems identified in this first section. We will now examine the specific problems posed by surrogate motherhood.

II. Surrogate Motherhood

A. Issues

1. Legality and Legitimacy[301]

As the law now stands, surrogacy runs counter to the principles of contract law. For both the civil and the common law, any contract or agreement, even where there is no payment, between a surrogate and prospective parents is quite probably null and void as

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OLRC, *supra*, note 2 at 22.

Further, there are doubts as to the ability of practitioners to carry out appropriate genetic screening of donors. See Lamport, *supra*, note 282 at 117. The author refers to Curie-Cohen, Luttrell and Shapiro, *supra*, note 282 at 588:

> Geneticists and others recognize that there is a serious lack of knowledge of genetics in those who perform artificial insemination. Donors are commonly screened for hereditary disorders, but the screening is illusory. Family histories are taken, but they are usually superficial. Biochemical testing is only performed in about 28.8% of the cases. . . . Of the doctors participating in the Curie-Cohen study, 92% said that they would reject a donor with a chromosomal translocation or trisomy, but only 12.5% actually examined the potential donor's karyotype to see if the chromosomes were abnormal. Also, 71.4% said that they would reject a donor who had hemophilia in his family, despite the fact that it is an X-linked trait and would be impossible for a man to transmit unless he carried the gene and exhibited the trait himself.

Lamport writes, "[t]o date, this is the only study of its kind." See also Barratt, Chauhan and Cooke, *supra*, note 161; and "Screening Gamete and Embryo Donations," *supra* at 32.

301. See *supra*, note 231.

being against public policy.[302] Moreover, such contracts are also at odds with a fundamental principle of family law: the custody of a child must be determined according to the best interests of the child rather than the wishes expressed by the parents in a contract.[303] Any agreement providing in advance for the handing over of the child at birth is illegal under provisions dealing with parental authority.[304]

Clearly, the absolute nullity of such an agreement does not prevent the parties from giving effect to a contract where the surrogate does not object to surrendering the child.[305]

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302. With respect to the common law, see Dickens, *supra*, note 218 at 71: "It is commonly accepted that, in the absence of approving legislation, surrogate motherhood agreements will be held void by the courts as against public policy." OLRC, *supra*, note 2 at 220: "Although not otherwise prohibited, it would appear that such arrangements are illegal and unenforceable at common law as being against public policy." With respect to the civil law, see Baudouin and Labrusse-Riou, *supra*, note 210 at 115; art. 582 of Bill 125, *supra*, note 196, is explicit: "Procreation or gestation agreements on behalf of another person are null." Recall, also, the U.S. decision in *Baby M*, 537 A. 2d 1227 at 1234 (N.J. 1988): "We invalidate the surrogacy contract because it conflicts with the law and public policy of this State."

303. The precedence of the best interests of the child over contractual freedom is made clear in such provisions as ss 52(1)(c), 53(1)(c) and 56(1) of Ontario's *Family Law Act, 1986*, *supra*, note 196. For example, s. 52(1)(c) reads:

> 52(1) A man and a woman who are married to each other or intend to marry may enter into an agreement in which they agree on their respective rights and obligations under the marriage or on separation, on the annulment or dissolution of the marriage or on death, including,
>
> ...
>
> (c) the right to direct the education and moral training of their children, but not the right to custody of or access to their children; ...

Paragraph 53(1)(c) provides likewise for persons "who are cohabiting or intend to cohabit." See also s. 56(1): "In the determination of a matter respecting the support, education, moral training or custody of or access to a child, the court may disregard any provision of a domestic contract pertaining to the matter where, in the opinion of the court, to do so is in the best interests of the child."

304. With respect to the common law, see the OLRC report, *supra*, note 2 at 99: "With respect to the common law ... the courts have long held that, subject to very few exceptions, parental rights and responsibilities are inalienable and incapable of transfer as a matter of contract." The illegality of such an agreement would be determined primarily by the interests of the child. Thus the Supreme Court has recognized that some custody agreements, the main objective of which were the best interests of the child, were not illegal; see *Chisholm* v. *Chisholm* (1908), 40 S.C.R. 115. *A contrario*, see *Re Hutchinson* (1913), 28 O.L.R. 114 (C.A.). See the discussion of surrogacy contracts and transfer of custody of the child in the OLRC report, *supra*, note 2 at 94-102. With respect to the civil law, see Rivet, *supra*, note 275 at 850: [TRANSLATION] "Abandoning in an agreement the rights that derive from parental authority is contrary to public policy, as is complete and definitive delegation of parental authority." The author refers to *Stevenson* v. *Florant*, [1925] S.C.R. 532; see also Jean-Louis Baudouin, *Les obligations*, 3d ed. (Cowansville, Que: Yvon Blais, 1989) at 83-84.

305. OLRC, *supra*, note 2 at 99-100:

> While a surrogate motherhood agreement may not be enforced as a matter of contract law, the existing legal regime does not make it completely impossible to give effect to the wishes of

We should point out, however, that this is made possible only through the application of rules governing filiation in both the civil law and the common law.[306]

Since the current law does not sanction surrogate motherhood and indirectly even permits it, we must ask if it would be appropriate to alter the situation. If so, legislation could be introduced that would make surrogacy contracts legal and set out the terms and conditions governing them, or would specifically prohibit such contracts as being contrary to public policy.

> [TRANSLATION]
> It may be that culture and traditional family law are drastically altered by the notion of surrogate motherhood, but surrogacy should not necessarily be seen as something negative to be restricted or prohibited. The mere fact of surrogacy means that a choice must be made between confirmation and prohibition in positive law.[307]

2. Commercial Aspects of Surrogacy

The monetary aspect of a surrogacy contract raises not only the potential for exploitation of the parties, but also the prospect of trade in children, which is currently prohibited in Canada by adoption and youth protection legislation:

> Though each Canadian province has its own legislation governing adoption, the basic statutory framework is similar throughout the country. The legislation restricts who may adopt a child and who may be adopted. Throughout North America concern exists about a practice sometimes known as baby farming, the unscrupulous placement of babies for adoption by operators motivated by a desire for profit and invariably acting with little regard for the welfare of the child. As a result, legislation restricts who may arrange adoptions and how they are to be arranged; in particular, there are restrictions about receiving payment for placing a child or doing other work in connection with an adoption.[308]

> the parties to such an agreement. There are procedures by which a child, born or about to be born to a surrogate mother, might be "naturalized" in the care and custody of the prospective social parents, at least where the social father is also the biological father. The focus of attention here is not on the validity or enforceability of a surrogate motherhood agreement, but on the steps that may be taken today where a child is born or about to be born and the surrogate mother is willing to transfer the child.

See also Baudouin and Labrusse-Riou, *supra*, note 210 at 127-28; Rivet, *supra*, note 275 at 850-51, regarding the use of adoption rules in Quebec.

306. See *infra* at 69ff.

307. Baudouin and Labrusse-Riou, *supra*, note 210 at 120.

308. Nicholas Bala, Heino Lilles and Georges Thomson, *Canadian Children's Law* (Toronto: Butterworths, 1982) at 284-85.

For example, subsection 33(2) of *The Adoption Act* of Saskatchewan reads as follows:

> (2) [N]o person shall:
>
> (a) give or receive; or
>
> (b) agree to give or receive;
>
> any payment or reward, whether directly or indirectly, for any purpose related to the adoption of a child.[309]

Since it is illegal to receive payment in return for arranging the adoption of a child, these provisions may also prohibit a surrogate who consents to the adoption of her child from being reimbursed for expenses.[310]

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309. *The Adoption Act*, S.S. 1989-90, c. A-5.1. In Quebec, see s. 135.1 of the *Youth Protection Act*, *supra*, note 281:

> Whether the placement or the adoption takes place in Québec or elsewhere and whether or not the child is domiciled in Québec, any person who
>
> (*a*) gives or receives or agrees to give or receive, directly or indirectly, a payment or a benefit either for finding a placement or contributing to a placement with a view to adoption, or for obtaining the adoption of a child, . . .
>
> is guilty of an offence and liable, on summary proceedings, in addition to costs, to a fine of $2 000 to $5 000, in the case of an individual, and to a fine of $5 000 to $10 000, in the case of a corporation.

This provision does not, however, invalidate the placement or adoption. See also *Child Welfare Act*, S.A. 1984, c. C-8.1, s. 71, as am. S.A. 1988, c. 15, s. 35; *Family Services Act*, (N.B.), *supra*, note 283, s. 95; *The Child and Family Services Act*, S.M. 1985-86, c. 8, ss 63 and 84; *The Adoption of Children Act, 1972*, S.N. 1972, No. 36, s. 5, as am. S.N. 1974, No. 9, s. 3 and S.N. 1979, c. 35, Sch. A, Item 1; *Child Welfare Act*, R.S.N.W.T. 1988, c. C-6, s. 108; *Children and Family Services Act*, S.N.S. 1990, c. 5, s. 69(3); *Adoption Act*, R.S.P.E.I. 1988, c. A-4, s. 23; *Children's Act* (Yukon), *supra*, note 197, s. 102. Ontario and British Columbia permit payment under certain conditions; see *Child and Family Services Act, 1984*, S.O. 1984, c. 55, ss 159-160, as am. S.O. 1987, c. 4, s. 8, and S.O. 1989, c. 72, s. 20, and *Adoption Act*, R.S.B.C. 1979, c. 4, as am. S.B.C. 1980, c. 36, s. 2. A decision by the British Columbia Supreme Court allowed the natural mother to be reimbursed by the adoptive couple for reasonable expenses related to the adoption of her child. Justice Huddart specified, however, "On another day and in other circumstances another judge might have different criteria but the adopting parents have established to my satisfaction that my criteria for approving a payment to the natural mother have been met.": *Re Adoption Act* (1982), 27 R.F.L. (2d) 72 at 75.

310. Dickens, *supra*, note 218 at 71: "Known participants complying with their terms in Canada have not been subjected to legal proceedings, for instance for violation of prohibitions against offering and receiving money for consent to adoption." For more information, see the U.S. decisions in *Baby M*, *supra*, note 302; *Doe* v. *Kelley*, 307 N.W. 2d 438 (1981), *certiorari* denied, 459 U.S. 1183 (1983); *Baby Girl*, 9 Fam. L. Rep. 2348 (1983), in which Justice Mudd refused to recognize the adoption of a child born to a surrogate mother by the genetic father and his wife. See also *Syrkowski* v. *Appleyard*, Civ. Action 81, 122 D.P. (1981), confirmed by 333 N.W. 2d 90 (1983) at 90: "The Court of Appeal, Cynar, P.J., held that the Paternity Act did not encompass the birth of a child which resulted from a financial transaction involving a surrogate mother." See, however, the opposite view in *In the Matter of Adoption of Baby Girl L.J.*, 505 N.Y.S. 2d 813 (1986), and *Surrogate Parenting Associates* v. *Commonwealth of Kentucky, ex rel Armstrong*, 704 S.W. 2d 209 (1986); R. Alta Charo, "Legislative Approaches to Surrogate Motherhood" (1988) 16:1-2 Law Med. Health Care 96 at 97.

It should be noted, however, that adoption laws in all provinces except Manitoba[311] are aimed solely at transactions intended to result in the adoption of a child. Any other transaction that does not constitute an adoption would therefore not be subject to these laws.

In the *Criminal Code* there are currently no provisions that specifically prohibit traffic in and the sale and purchase of children. On the other hand, the offences referred to in sections 279(1) (kidnapping), 279.1 (hostage taking), 280 (abduction of person under sixteen), 281 (abduction of person under fourteen), 282 (abduction in contravention of custody order) and 283 (abduction where no custody order) are not appropriate charges in all situations involving surrogate motherhood.[312]

B. Children

1. Legal Parentage

We have already outlined the problems the various technologies of medically assisted procreation pose for parentage law.[313] We must now consider the specific problem of the parentage of children born to a surrogate.

The parentage of a child born to a surrogate can depend on a number of factors, among them whether or not the woman voluntarily surrenders the child; whether the woman is married or single; and whether the surrogate provides the ovum or is only the gestational mother.[314]

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311. Unlike the other provinces, Manitoba does not limit the offence to adoption. Section 84 of *The Child and Family Services Act*, *supra*, note 309 reads as follows:

> Any person who gives or receives or agrees to give or to receive any payment or reward either directly or indirectly in consideration for
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> (a) the purported sale of a child for any purpose; or
>
> (b) procuring or assisting in procuring the purported sale of a child for any purpose;
>
> is guilty of an offence punishable on summary conviction and liable to a fine of not less than $1,000.00 and not more than $10,000.00 or to imprisonment for a term not exceeding 6 months or both.

312. The Uniform Law Conference of Canada raised the various problems encountered by these provisions in the area of surrogate motherhood. See "Trafficking in Children" in Uniform Law Conference of Canada, *Proceedings of the Seventy-second Annual Meeting Held at Saint John, New Brunswick, August, 1990* (Fredericton, N.B.: The Conference, 1991) at 324.

313. *Supra* at 56ff.

314. See Jacqueline Rubellin-Devichi, "Les procréations assistées: état des questions" (1987) 86:3 Rev. trim. dr. civ. 457 at 489ff.

If an unmarried surrogate surrenders the child at birth, she will nevertheless be deemed to be the legal mother but she may also consent to adoption by the father's wife.[315] If she does not so consent, a motion may in theory be filed seeking deprivation of the surrogate's parental authority for having abandoned the child.

If an unmarried surrogate refuses to surrender the child, the social father, if he is also the child's biological father, may claim paternity.[316] He must also file an application for custody with the court, which will rule on the application according to the best interests of the child.[317]

If there is no dispute (the child is surrendered) but the surrogate is married, her husband is presumed to be the child's father.[318] The appropriate procedure is for the surrogate's

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315. See Rivet, *supra*, note 275 at 850-52. See also the recent decision in *Re Ontario Birth Registration Number 88-05-045846* (12 February 1990), Windsor A012/89 (Ont. Prov. Ct), wherein the judge approved the adoption of a child whose mother had been artificially inseminated with her father-in-law's sperm under a surrogacy agreement.

316. Dickens, *supra*, note 218 at 68:

> Some donors ... intend specifically to rear the children born to women who have acted as surrogate mothers. ... All these expectations, however, are subject to displacement, sometimes quite arbitrarily, by legislative provisions drafted with no regard for the different forms of artificial insemination and reproduction. The *Nova Scotia Family Maintenance Act*, for instance, defines a "possible father" as one who has "had sexual intercourse with ... the mother of a child," thereby excluding a donor for asexual reproduction.

See also art. 589 *C.C.Q.*

317. *Canadian Family Law Guide*, *supra*, note 274 at 2461: "The conflict between the common law principle of the *prima facie* right of a mother to the custody of her illegitimate child and the equitable principle that the welfare of the child is the paramount consideration is reflected in the case law relating to custody disputes between the parents of illegitimate children." See also at 2470, which quotes the decision in *D.(W.)* v. *P.(G.)*, [1984] 5 W.W.R. 289 (Alta C.A.):

> The traditional rule is that the natural father of a child born out of wedlock is a deemed stranger to the child. As such, he cannot wrest custody of the child from the mother without first demonstrating that she has either abandoned or neglected the child, or without offering other serious or commanding reasons. That is a court-made rule, however, and as such can be changed by the court.

318. Dickens, *supra*, note 218 at 69-70: "[A] sperm donor who seeks to establish his paternity may face legal obstacles, particularly if his object is to assert custody rights to a child born of a surrogate motherhood agreement made with a married woman." Knoppers and Sloss, *supra*, note 269 at 716: "Presumptions of paternity ... with respect to children born of artificial insemination would work against any biological father where the gestational mother was married or cohabiting with a man."

husband to disavow his paternity or for the surrogate herself to challenge her husband's paternity.[319] The biological father may then claim paternity.[320]

If a married surrogate refuses to surrender the child at birth, the social father will have to challenge the presumed paternity of the husband before it is confirmed by possession of status, in order to establish his own paternity through evidence that he is the biological father.

Even if the surrogate is not genetically linked to the child and there is a dispute, she will probably be deemed the legal mother. However, we may ask whether it would be possible for the genetic mother to challenge the gestational mother's maternity and file a claim of maternity on the grounds of her genetic link to the child.[321] Since the rule that establishes maternity by the fact of childbirth is not a substantive rule but a rule of

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319. In Quebec, see art. 581 *C.C.Q.*, subject to application of the defences at bar in art. 586 *C.C.Q.* to medically assisted procreation technologies other than artificial insemination. Note that art. 580 of Bill 125, *supra*, note 196, eliminates this ambiguity. For the Yukon and Newfoundland, see *supra*, note 277. See Knoppers, *supra*, note 284 at 220. Since, in the common law provinces, the presumption of paternity is rebuttable, a challenge to paternity may be made provided the evidence is sufficiently clear and convincing. Accordingly, the *Canadian Family Law Guide*, *supra*, note 274 at 2401, para. 4305, states:

> It is a strong presumption in law that children born in wedlock are in fact the legitimate offspring of the husband and wife. Where the husband had opportunity of access, a mere denial of paternity is not enough to rebut the presumption (*Re Johnston and Johnston* (1975), 10 O.R. (2d) 249 (Prov. Ct); *Guevara* v. *Guevara* (1976), 28 R.F.L. 30 (Man. Q.B.)); nor is an admission of paternity by another (*Re Brown and Argue*, [1925] 3 D.L.R. 873 (Ont. C.A.); *Re Anderson*, [1947] 3 D.L.R. 302 (N.B.C.A.)). Admission of paternity by another, however, when coupled with a temporary assumption of the child's support and cohabitation with the mother, was found to be enough to rebut the presumption in *Gray* v. *Foster* (1974), 19 R.F.L. 12 (Ont. Prov. Ct).

See also *B.(B.J.)* v. *K.(J.)*, *supra*, note 274 at 151:

> The presumption may be rebutted by evidence which satisfies the court, on the balance of probabilities, that the child's mother and her husband did not engage in sexual intercourse by which the child could have been conceived. The H.L.A. tissue typing test results should be taken into account, together with all the other relevant evidence, in determining whether the respondent has met the onus placed upon him. The weight given to the test results depends on the credibility of the parties.

320. For Quebec, see art. 589 *C.C.Q.* For the common law provinces, see Dickens, *supra*, note 279 at 355:

> In a surrogate motherhood transaction involving a married woman, her husband's name might have to be recorded as father of the child, leaving the intended father to seek a separate judicial declaration of paternity before he could gain a right of custody. He might also have to adopt his child before a birth certificate could be issued naming him as his child's father.

Dickens, *supra*, note 218 at 70: "In contrast to an ovum donor, a man entering an agreement and donating his sperm for the insemination will in law be entitled to recognition as father of the child."

321. See Martine Nolin and Héleine Guay, "Le phénomène des femmes porteuses: le droit à l'écoute de la science et de la société" in Martine Nolin, *Réflexions juridiques sur le phénomène des femmes porteuses d'enfants* (Cowansville, Que.: Yvon Blais, 1986) at 54; see also Rubellin-Devichi, *supra*, note 314 at 488.

evidence[322] — it does not appear in any legislation — and by analogy with the establishment of paternity,[323] some analysts claim that it would be possible to rebut the presumption of maternity on the basis of genetic filiation.[324]

In any event, it is clear from this brief review of the various issues that the current rules are inadequate.[325]

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322. Monique Bandrac, "Réflexions sur la maternité" in *Mélanges offerts à Pierre Raynaud* (Paris: Dalloz-Sirey, 1985) 27 at 30: [TRANSLATION] "While the result is surely that evidence of childbirth is enough to establish maternity, the fact of delivery is by no means the very essence of the link, and one could not seriously argue that the authors of the *Code civil* intended to settle, through the evidentiary scheme they established, a substantive problem of which they did not have the faintest idea."

323. *Ibid.* at 30-31:

> [TRANSLATION]
> It springs from the need imposed on the interpreter to adopt in respect of the father and the mother the same notion of the biological element whose role is today predominant in the components of blood parentage. . . . The basis for paternity then lies in heredity, and it seems that it is heredity as well, that is, the furnishing of a root cell, which forms the primary biological foundation of maternal parentage.

324. Knoppers and Sloss, *supra*, note 269 at 716:

> If the gestational mother refused to surrender custody the law would presume her right to the child as its gestational mother subject to later proof of paternity. If the child was actually the result of *in vitro* fertilization utilizing the sperm and ovum of the social parents, the societal parents would have recourse against her only in so far as they could prove their genetic link to the child.

However, this situation is subject to unchallengeable presumptions of paternity in cases where artificial insemination is used, if these provisions apply to gestational surrogate mothers; see *supra*, note 277. Faced with the division of the biological and gestational aspects of motherhood, a Michigan court recognized the right of the genetic parents to have their names on the birth certificate and to be deemed the legal parents. *Smith* v. *Jones* (14 March 1986), Michigan 8553201460 Wayne Co. Cir. Ct, in Sherrill Cohen and Nadine Taub, eds, *Reproductive Laws for the 1990s* (Clifton, N.J.: Humana, 1989) at 383. In a recent U.S. decision we find the following comment:

> [A] surrogate mother has lost her bid to be named the third parent of a test-tube baby she bore for an infertile couple.
>
> Judge Richard Parslow of the U.S. Superior Court [*sic*] ruled . . . that Anna Johnson does not have any parental rights to the baby boy born a month ago, and he granted permanent custody to Mark and Crispina Calvert, the couple who paid Ms Johnson $10,000 (U.S.) to carry their fertilized embryo. . . .
>
> Despite her contribution, the judge said, 'a surrogate carrying a genetic child for a couple does not acquire parental rights.'

Murray Campbell, "Woman Loses Bid to Be Parent" *The* [*Toronto*] *Globe and Mail* (23 October 1990) A-14. On appeal, the decision was affirmed: see *Anna J.* v. *Mark C.*, 286 Cal. Rptr. 369 (1991).

325. The Uniform Law Conference of Canada, in *An Act to amend the Uniform Child Status Act*, *supra*, note 199, proposes the following amendments:

> 11.3. A woman who gives birth to a child before or after the coming into force of this section is deemed to be the mother of the child whether or not the child is conceived using the woman's egg.
>
> . . .
>
> 11.4(1) A woman whose egg is used in an assisted conception and who does not give birth to the child conceived using her egg is deemed not to be the mother of the child.

2. Custody

From parentage stems parental authority,[326] and parental authority is the basis for custody. In medically assisted procreation, if parentage is established as vesting in the surrogate and her husband, they will have custody of the child unless they are deprived of their parental authority[327] and/or unless the interests of the child prevent them from retaining custody.[328]

On the other hand, if legal parentage is established as vesting in the surrogate and the social father, it may be difficult to determine custody of the child. The criterion then is the best interests of the child,[329] as determined in light of the circumstances in each case.[330]

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326. D.-Castelli, *supra*, note 271 at 182.

327. To deprive a person of parental authority, it must first be demonstrated that the holder of such authority "has been guilty, by action or inaction, of a serious and unjustified failure to perform the parental duty" (*C. (G.)* v. *V.-F. (T.)*, [1987] 2 S.C.R. 244 at 246). Further, such deprivation must be in the interest of the child (see art. 654 *C.C.Q.* and art. 606 of Bill 125, *supra*, note 196). See also Dickens, *supra*, note 218 at 71-72.

328. With respect to the common law, see Dickens, *supra*, note 218 at 52:

> In most cases ... the State's role is now seen to be to pursue the individual child's best interests, established by legal process. In the conflict between the ... two principles [the "natural rights" of the parents and the best interests of the child], it seems to be accepted, in Canada and elsewhere in the common law world, that the "best interests of the child" principle has prevailed.

See also M. Joyce Schlosser, "Third Party Child-Centred Disputes: Parental Rights v. Best Interest of the Child" (1984) 22 Alta L. Rev. 394 at 398 and 401. With respect to the civil law, see D.-Castelli, *supra*, note 271 at 185; the author refers to the Supreme Court decision in *C. (G.)* v. *V.-F. (T.)*, *supra*, note 327, in which the interest of the child was affirmed as a primary consideration. In the ruling, custody was awarded to third parties, taking into account the interest of the children without deprivation of parental authority or loss of custody rights. Beetz J. at 266-67: "In such a situation, the holder is deprived of the exercise of custody but not of the right itself."

329. D.-Castelli, *supra*, note 271 at 186. See art. 30 *C.C.L.C.* and arts 33 and 34 of Bill 125, *supra*, note 196. See also *Divorce Act, 1985*, S.C. 1986, c. 4. For the determination of the interests of the child, see *ibid.* ss 16(8) and (10) and 17(9). See Dickens, *supra*, note 218 at 72. Dickens refers to the following observation by Dubin J. in *Re Moores and Feldstein* (1973), 38 D.L.R. (3d) 641 at 647 (Ont. C.A.): "I do not think it safe to proceed on the assumption that a child will receive greater love and a more understanding upbringing if it is returned to a mother who did not want it at the time of its birth, than it would if left in the hands of those who sought it out for their love and care." Professor Dickens comments:

> Similarly, it would be perverse, and possibly harmful to the child's best interests, to place the child with strangers, when the father had not been shown to have violated legally mandated minimum standards of child protection. ... In Ontario ... section 55(1) of the Family Law Reform Act, [now section 56 of the *Family Law Act, 1986*, *supra*, note 196] provides that: "In the determination of any matter respecting ... custody of or access to a child, the court may disregard any provision of a domestic contract pertaining thereto where, in the opinion of the court, to do so is in the best interests of the child." This provision embodies the position at common law, and is applicable in principle to disputed custody of a child born in a surrogacy agreement.

In *Clark* v. *Clark* (1952), O.W.N. 671 at 671-72 (H.C.), Barlow J. stated this position thus: "The agreement as to custody is not binding on the Court if the Court in its discretion is of the opinion that it is not in the best interests of the child's physical, moral, emotional and spiritual welfare." See also the OLRC report, *supra*, note 2 at 96-97; and the U.S. decision in *Baby M*, *supra*, note 302.

330. See Dickens, *supra*, note 218 at 53: "[T]he concept of 'best interests' has become interpreted to mean the 'least detrimental alternative'."

The parent who is not granted custody nevertheless retains parental authority, but the ability to exercise that authority may be reduced to a simple right of supervision.[331] The parent without custody may also enjoy access rights, but such rights are neither automatic nor guaranteed.

There are two options open to lawmakers: either to resolve the custody problem by giving legal effect to the private agreement between the surrogate and the prospective parents, or to let the dispute be resolved according to the interests of the child.

In summary, the problematic issues here are the contractual and commercial aspects of surrogate motherhood, and the parentage and custody of the resulting child. We will return to these issues in our chapter of recommendations.

III. The *Canadian Charter of Rights and Freedoms*

To complete our study of the different legal questions raised by medically assisted procreation, we will examine the impact that the *Canadian Charter of Rights and Freedoms* is likely to have on any attempt by the government to regulate the use of and access to reproductive technologies.[332]

We will first examine whether a right to procreate is entailed in the right to liberty and security of the person enshrined in section 7 of the *Charter*, and whether such a right would entail a right of access to in vitro fertilization, artificial insemination, or a right to enforce a surrogacy contract. We will then turn to section 15 of the *Charter*, and discuss the impact that equality rights are likely to have on possible attempts to limit access to reproductive technologies. We conclude with a brief discussion of section 1 of the *Charter*.

But first it is necessary to stress that, in the absence of legislative regulation or other government intervention, the issues raised by medically assisted procreation are not constitutional issues. Pursuant to section 32, the *Charter* applies "to the Parliament and government of Canada" and "to the legislature and government of each province": it does not apply directly to the activities of private individuals.[333] Accordingly, the activities of doctors, hospitals or other non-governmental individuals or entities are not subject to the *Charter* unless their practices or policies are dictated by the government.[334]

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331. See D.-Castelli, *supra*, note 271 at 190-91.

332. The question of the constitutional division of legislative powers relating to these issues will not be addressed here.

333. *RWDSU* v. *Dolphin Delivery Ltd.*, [1986] 2 S.C.R. 573.

334. See *McKinney* v. *University of Guelph*, [1990] 3 S.C.R. 229; *Harrison* v. *University of British Columbia*, [1990] 3 S.C.R. 251; *Douglas/Kwantlen Faculty Assn.* v. *Douglas College*, [1990] 3 S.C.R. 570; *Stoffman* v. *Vancouver General Hospital*, [1990] 3 S.C.R. 483.

Thus, a decision by government to abstain from regulating reproductive technologies will not give rise to constitutional challenges.[335] On the other hand, a decision to regulate the use of and access to reproductive technologies will give rise to a number of potential *Charter* challenges. In particular, a legislative restriction on access to reproductive technologies may violate either section 7 or section 15 of the *Charter*.

A. Section 7: The Right to Life, Liberty and Security of the Person

Section 7 reads as follows:

> *Everyone* has the right to life, liberty and security of the person *and* the right not to be deprived thereof except in accordance with the principles of fundamental justice [emphasis added].

The "and" in the middle of the text (as well as the semi-colon used in the French version) suggests that the section could be read disjunctively to provide two rights, both a right to "life, liberty and security of the person" and a right "not to be deprived thereof except in accordance with the principles of fundamental justice." However, the courts have rejected this interpretation, finding that section 7 provides one right, a right not to be deprived of life, liberty or security of the person except in accordance with the principles of fundamental justice.[336] Thus, establishing a violation of section 7 involves a two-step process: first, an individual must establish that his or her right to life, liberty or security of the person has been violated,[337] and second, that the violation was not in accordance with the principles of fundamental justice.

The term "everyone" raises the question of whether the unborn are included and can thus claim the benefit of the right not to be deprived of life except in accordance with the principles of fundamental justice. If the unborn do have section 7 rights, or if they are "individuals" for the purposes of section 15, then the *Charter* could have an impact, for example, on the handling of embryos frozen for purposes of IVF.

Prior to the enactment of the *Charter*, Canadian law recognized the legal existence of a fetus only upon its subsequent live birth.[338] The courts that have addressed the issue

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335. Of course, actions by non-governmental individuals or entities restricting access to reproductive technologies could be the subject of complaints under provincial human rights codes if individuals are discriminated against on the grounds of sex, family status, marital status, or sexual orientation.

336. See *Singh* v. *Minister of Employment and Immigration*, [1985] 1 S.C.R. 177; *R.* v. *Jones*, [1986] 2 S.C.R. 284; *R.* v. *Morgentaler*, [1988] 1 S.C.R. 30.

337. The case law has established that the three interests protected by s. 7 — life, liberty and security of the person — are independent interests each of which must be given independent meaning. See *Singh*, *supra*, note 336 at 204-05; *Reference re Section 94(2) of the* Motor Vehicle Act *(B.C.)*, [1985] 2 S.C.R. 486 at 500; *Morgentaler*, *supra*, note 336 at 52.

338. See *Montreal Tramways Company* v. *Léveillé*, [1933] S.C.R. 456; *Duval* v. *Seguin* (1972), 26 D.L.R. (3d) 418 (Ont. H.C.); *Dehler* v. *Ottawa Civic Hospital* (1979), 25 O.R. (2d) 748 (H.C.), aff'd (1980) 29 O.R. (2d) 677 (C.A.), leave to appeal to S.C.C. refused, [1981] 1 S.C.R. viii; *Langlois* v. *Meunier*, [1973] C.S. 301.

under the *Charter* have followed the traditional common law position and held that the unborn do not have *Charter* rights.[339] This position is consistent with the law in the United States,[340] in England[341] and under the European *Convention for the Protection of Human Rights and Fundamental Freedoms*.[342] By contrast, the Irish Constitution explicitly protects the right to life of the unborn,[343] and courts in former West Germany have found that a fetus falls within the constitutional guarantee of the right to life.[344]

The Supreme Court recently declined to resolve this issue in *Borowski* v. *Canada (Attorney General)*,[345] holding that the issue was moot and that the appellant no longer had standing to pursue the action.[346] Notwithstanding this uncertainty, it seems unlikely that the traditional Anglo-Canadian position on the rights of the unborn will be reversed under the *Charter*.[347] Accordingly, we will proceed on the basis that the legal treatment of a fetus or embryo is not subject to constitutional constraints flowing from the constitutional status of the unborn.

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339. *Borowski* v. *Attorney-General for Canada* (1987), 39 D.L.R. (4th) 731 (Sask. C.A.); *Campbell* v. *Attorney-General of Ontario* (1987), 58 O.R. (2d) 209 (H.C.), aff'd (1987) 60 O.R. (2d) 617 (C.A.), leave to appeal to the Supreme Court refused, [1987] 1 S.C.R. vi. But see the recent decision of the Quebec Court of Appeal in *Daigle*, *supra*, note 219, in which the Court held, three to two, that a fetus has a right to life under the Quebec Charter, *supra*, note 255. However, this judgment was reversed by a unanimous decision of the Supreme Court of Canada.

340. See *Roe* v. *Wade*, 410 U.S. 113 at 161 (1973): "[T]he law has been reluctant to endorse any theory that life, as we recognize it, begins before live birth or to accord legal rights to the unborn except in narrowly defined situations and except when the rights are contingent upon live birth." However, in a recent ruling, *Webster* v. *Reproductive Health Services*, 492 U.S. 490 at 518 and 526 (1989), a majority of the Court indicated that the decision in *Roe* may be overruled in the near future. Four judges subscribed to the view that *Roe* was "unsound in principle and unworkable in practice," and Justice O'Connor suggested that the Court should "reexamine Roe ... carefully" in a future case.

341. *Paton* v. *Trustees of BPAS*, [1978] 2 All E. R. 987 at 989 (Q.B.): "The foetus cannot, in English law, in my view, have any right of its own at least until it is born and has a separate existence from its mother."

342. Also known as *European Convention on Human Rights* (1955) 213 U.N.T.S. 221. See *Paton* v. *United Kingdom* (1980), 3 E.H.R.R. 408: a fetus does not have a right to life under art. 2 of the Convention, at least not in the initial stages of pregnancy.

343. Section 40.3.3, added to the Irish Constitution after a referendum in 1983, provides that: "The state acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and as far as practicable, by its laws to defend and vindicate that right."

344. See the discussion in *Borowski* (1987), *supra*, note 339 at 747-48.

345. [1989] 1 S.C.R. 342.

346. The 1989 *Borowski* case, *supra*, note 345, began as a challenge to s. 251, the old therapeutic abortion provision of the *Criminal Code*. In January 1988, the Supreme Court released its decision in *Morgentaler*, *supra*, note 336, in which s. 251 was struck down as a violation of a woman's rights under s. 7 of the *Charter*. Thus, when the *Borowski* appeal was argued later in the year, the legal basis for the challenge no longer existed.

347. For a full discussion of the many legal and ethical difficulties that would follow from such a holding, see Catherine Tolton, "Medicolegal Implications of Constitutional Status for the Unborn: 'Ambulatory Chalices' or 'Priorities and Aspirations'" (1988) 47 U.T. Fac. L. Rev. 1.

1. The Right to Procreate

Is a right to procreate entailed in the right to life, liberty or security of the person? Surely, a person's life is not threatened by a denial of access to reproductive technologies. At the most, it is the possibility of creating a new life that is being denied to the person. Thus, an individual's "right to life" is not relevant here. However, it may be that the right to have access to the means to attempt procreation is an element of either the right to liberty or the right to security of the person.

The meaning of the "right to liberty" has yet to be clearly set out by the Supreme Court of Canada. At least we know that the phrase encompasses deprivations of physical liberty such as imprisonment.[348] Beyond instances of physical restraint, it is, as the Court has noted, a phrase "capable of a broad range of meaning."[349] Yet thus far only Justice Wilson has explored in her judgments the potential breadth of the "liberty" protected by section 7: the other justices have not yet found occasion to do so. For example, in *R.* v. *Jones*,[350] Justice La Forest was willing to assume that the right to liberty included a "right of parents to educate their children as they see fit," but he did not find it necessary to decide the issue.

Justice Wilson has articulated a definition of liberty that would entail a right to procreate. In her view,

> the right to liberty contained in s. 7 guarantees to every individual a degree of personal autonomy over important decisions intimately affecting their private lives.[351]

In *Jones*,[352] she held that the right to liberty protects the parents' right to raise their children in accordance with their conscientious beliefs. In *Morgentaler*,[353] she held that a woman's decision whether or not to terminate a pregnancy fell within the class of decisions protected from state interference by the right to liberty. Such a decision has "profound psychological, economic and social consequences for the pregnant woman."[354] Could we not say the same about the decision to bear and raise a child conceived with the assistance of a reproductive technology?

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348. See *Reference re Section 94(2) of the* Motor Vehicle Act *(B.C.)*, *supra*, note 337.

349. See *Singh*, *supra*, note 336 at 206.

350. *Supra*, note 336 at 302.

351. See *Morgentaler*, *supra*, note 336 at 171. See also *Jones*, *supra*, note 336 at 318, where Justice Wilson offered the following rationale for the right to liberty:

> I believe that the framers of the Constitution in guaranteeing "liberty" as a fundamental value in a free and democratic society had in mind the freedom of the individual to develop and realize his potential to the full, to plan his own life to suit his own character, to make his own choices for good or ill, to be non-conformist, idiosyncratic and even eccentric — to be, in to-day's parlance, "his own person" and accountable as such.

352. *Supra*, note 336.

353. *Supra*, note 336.

354. *Ibid.* at 171.

In defining liberty, Justice Wilson relied heavily on a series of U.S. constitutional cases establishing an area of personal autonomy over reproductive decisions as an element of the constitutional guarantee of "liberty" in the due process clause of the Fourteenth Amendment. For example, in *Singh*[355] and *Jones*,[356] she relied on a passage in *Meyer* v. *Nebraska*[357] in which the United States Supreme Court stated that:

> [Liberty] denotes not merely freedom from bodily restraint but also the right of the individual ... to marry, establish a home and bring up children ... .[358]

And in *Morgentaler*,[359] Justice Wilson approved of the U.S. cases, discussed below, that established a right of access to contraception and abortion as an element of liberty protected by the Fourteenth Amendment. In sum, Justice Wilson's position is that liberty would be infringed by any state interference with an individual's access to the means to procreate. However, whether such a broad conception of liberty will garner the support of the majority of the Court remains to be seen.

The right to security of the person, like the right to liberty, is capable of a broad range of meaning.[360] The core meaning of the concept, in the words of then Chief Justice Dickson in *Morgentaler*, is that "the human body ought to be protected from interference by others."[361] In *Singh*, Justice Wilson stated that security of the person protects an individual from the threat of physical punishment or suffering as well as freedom from the actual punishment or suffering itself.[362] And the courts have indicated that security of the person extends to the control of one's psychological well-being as well as one's physical integrity.[363] As Justice Lamer argued in *Mills* v. *The Queen*:[364]

> [S]ecurity of the person is not restricted to physical integrity; rather, it encompasses protection against "overlong subjection to the vexations and vicissitudes of a pending criminal accusation." ... These include stigmatization of the accused, loss of privacy, stress and anxiety resulting from a multitude of factors, including possible disruption of family, social life and work, legal costs, uncertainty as to the outcome and sanction.[365]

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355. *Supra*, note 336 at 205.

356. *Supra*, note 336 at 317-18.

357. 262 U.S. 390 (1923).

358. *Ibid.* at 399.

359. *Supra*, note 336 at 167-71.

360. *Singh*, *supra*, note 336 at 206.

361. *Supra*, note 336 at 53.

362. *Supra*, note 336 at 207.

363. *R.* v. *Videoflicks Ltd* (1984), 48 O.R. (2d) 395 at 433 (C.A.).

364. [1986] 1 S.C.R. 863.

365. *Ibid.* at 919-20.

In *Morgentaler*, the five majority justices found that serious state-imposed psychological stress violated security of the person. Justice Beetz held that security of the person "include[s] a right of access to medical treatment for a condition representing a danger to life or health without fear of criminal sanction."[366] According to then Chief Justice Dickson,

> state interference with bodily integrity and serious state-imposed psychological stress, at least in the criminal law context, constitute a breach of security of the person. It is not necessary in this case to determine whether the right extends further, to protect either interests central to personal autonomy, such as a right to privacy, or interests unrelated to criminal justice.[367]

It is possible that the anxiety and stress caused to a person otherwise unable to procreate by the denial of access to reproductive technology could fall within the definition of security of the person offered by the justices in the *Morgentaler* case. However, as then Chief Justice Dickson noted, the psychological component of security of the person has yet to be applied by the Supreme Court outside the context of a criminal prosecution.

The Court has also yet to decide whether security of the person extends beyond the protection of physical or psychological integrity to a broader right of privacy or autonomy that might encompass the right to procreate and other rights related to family life. However, a number of lower courts have suggested that security of the person does entail a right of autonomy over personal and intimate decisions.[368]

Given the uncertainty regarding the meaning of "liberty" and "security of the person" in these early stages of *Charter* interpretation, it will be useful to consider the U.S. constitutional jurisprudence as it relates to the right to procreate. As we noted above, Justice Wilson found it useful in interpreting section 7 of the *Charter*, and in the absence of guiding Canadian precedent, U.S. case law will continue to be an influential source for *Charter* interpretation.

The United States Supreme Court first recognized the importance of procreative autonomy in *Skinner* v. *Oklahoma*, holding that forced sterilization of habitual criminals violated the equal protection clause.[369] Justice Douglas termed the right to have offspring "a sensitive and important area of human rights. ... a right which is basic to the perpetuation of a race."[370] Later in the opinion he added that:

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366. *Supra*, note 336 at 81.

367. *Ibid.* at 56.

368. See *Re T and Catholic Children's Aid Society* (1984), 46 O.R. (2d) 347 (Prov. Ct) (right to security of the person includes the right to individual privacy or family autonomy); *S. (S.)* v. *Director of Child and Family Services*, [1987] 5 W.W.R. 309 (Man. Q.B.) (same); *R.L. Crain Inc.* v. *Couture* (1983), 6 D.L.R. (4th) 478 at 502 (Sask. Q.B.): "[T]he phrase 'security of the person' includes a right to personal dignity and a right to an area of privacy or individual sovereignty into which the State must not make arbitrary or unjustified intrusions."

369. 316 U.S. 535 (1942).

370. *Ibid.* at 536.

> We are dealing here with legislation which involves one of the basic civil rights of man. Marriage and procreation are fundamental to the very existence and survival of the race. . . . [The person sterilized by the state] is forever deprived of a basic liberty.[371]

Most of the U.S. cases protecting procreative autonomy have relied on the right to privacy guaranteed by the Fourteenth Amendment. Although the U.S. Constitution does not explicitly recognize a right of privacy, the Court has found that one aspect of "liberty" protected by the due process clause of the Fourteenth Amendment is "a right of personal privacy, or a guarantee of certain areas or zones of privacy."[372] This right to personal privacy includes "the interest in independence in making certain kinds of important decisions,"[373] such as the choice to make use of contraceptives to avoid procreation.[374] As Justice Brennan put it:

> If the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.[375]

The Court has also recognized the rights to marry and to raise and educate children as fundamental rights under the Fourteenth Amendment.[376] Similarly, in 1973 the Supreme Court held that the right to privacy outlined in these cases was "broad enough to encompass a woman's decision whether or not to terminate her pregnancy."[377] The Court has held, however, that the state may refuse to pay for abortions[378] even if they are medically necessary to preserve the mother's life or health,[379] and that the state may prohibit the performance of abortions by public employees or in public hospitals.[380]

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371. *Ibid.* at 541.

372. *Roe* v. *Wade*, *supra*, note 340 at 152.

373. *Whalen* v. *Roe*, 429 U.S. 589 at 599-600 (1977).

374. *Griswold* v. *Connecticut*, 381 U.S. 479 (1965) (state cannot make the use of contraceptives by married persons a crime); *Eisenstadt* v. *Baird*, 405 U.S. 438 (1972) (invalidating a regulation which made contraceptives less available to the unmarried than to married couples); *Carey* v. *Population Services International*, 431 U.S. 678 (1977) (invalidating a state ban on the commercial distribution of non-medical contraceptives). See *Carey*, *ibid.* at 687: "Read in light of its progeny, the teaching of Griswold is that the Constitution protects individual decisions in matters of childbearing from unjustified intrusion by the State."

375. *Eisenstadt*, *supra*, note 374 at 453.

376. *Loving* v. *Virginia*, 388 U.S. 1 (1967) (race may not be a basis for restricting an individual's right to marry); *Zablocki* v. *Redhail*, 434 U.S. 374 (1978) (striking down a statute requiring a certain class of state residents to obtain court permission to marry); *Meyer*, *supra*, note 357 at 399 (recognizing a constitutional right to "marry, establish a home and bring up children"); *Pierce* v. *Society of Sisters*, 268 U.S. 510 (1925) (child rearing and education).

377. *Roe* v. *Wade*, *supra*, note 340 at 170. See also *Planned Parenthood of Missouri* v. *Danforth*, 428 U.S. 52 (1976); *Akron (City of)* v. *Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983); *Thornburgh* v. *American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986).

378. *Maher* v. *Roe*, 432 U.S. 464 (1977).

379. *Harris* v. *McRae*, 448 U.S. 297 (1980).

380. *Webster*, *supra*, note 340.

The right to privacy in U.S. constitutional law thus protects the individual from state interference with his or her procreative potential. In addition, an individual has the right to be free from state interference with his or her access to the means of contraception. However, the state has no obligation to provide the individual with resources adequate to ensure access to the means of contraception.

Courts in the United States have not yet resolved the issue of whether the right to privacy includes the right to have access to existing reproductive technology free from state interference. A number of authors have argued that the right to privacy entails the right to unrestricted access to the means to attempt to conceive, John Robertson being the most forceful advocate of this position.[381] In his view, any state regulation of access to reproductive technologies must be justified by a compelling state purpose: "the state must carry the burden of showing actual harm from [the] use of these techniques."[382] But, as Knoppers observes, the ultimate judicial recognition of a constitutional right to procreate by whatever means available as an expression of personal liberty or privacy is uncertain,[383] particularly in light of the current Supreme Court's reluctance to expand this branch of substantive due process.[384]

If uncertainty on these issues reigns under the U.S. Constitution, this is all the more true in Canada, where *Charter* jurisprudence is still in its early stages. In only one case thus far has a Canadian court faced an argument that a right to procreate is included in section 7. In *E. (Mrs.)* v. *Eve*,[385] the Supreme Court considered whether a court had the power, under its *parens patriae* jurisdiction, to authorize the non-therapeutic sterilization of a mentally handicapped woman. The Court concluded as follows:

> The grave intrusion on a person's rights and the certain physical damage that ensues from non-therapeutic sterilization without consent, when compared to the highly questionable advantages that can result from it, have persuaded me that it can never safely be determined that such a procedure is for the benefit of that person. Accordingly, the procedure should never be authorized for non-therapeutic purposes under the *parens patriae* jurisdiction.[386]

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381. See John A. Robertson, "Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth" (1983) 69 Va. L. Rev. 405; "Embryos, Families, and Procreative Liberty: The Legal Structure of the New Reproduction" (1986) 59 S. Cal. L. Rev. 939; "Decisional Authority over Embryos and Control of IVF Technology" (1988) 28:3 Jurimetrics 285. See also Barbara Kritchevsky, "The Unmarried Woman's Right to Artificial Insemination: A Call for an Expanded Definition of Family" (1981) 4 Harv. Women's L.J. 1; Andrea E. Stumpf, "Redefining Mother: A Legal Matrix for New Reproductive Technologies" (1986) 96 Yale L.J. 187.

382. John A. Robertson, "Procreative Liberty and the State's Burden of Proof in Regulating Noncoital Reproduction" (1988) 16:1-2 Law Med. Health Care 18 at 24.

383. Knoppers, *supra*, note 221 at 348-49.

384. See *Bowers* v. *Hardwick*, 478 U.S. 186 (1986).

385. [1986] 2 S.C.R. 388.

386. *Ibid.* at 431.

Relying on U.S. precedent, counsel for the party seeking the sterilization argued before the Court that section 7 entailed a right to free procreative choice, including a right to choose to have or not to have children and to implement that choice by means of contraception.[387] Justice La Forest, speaking for the Court, did not find it necessary to decide this point:

> [A]ssuming for the moment that liberty as used in s. 7 protects rights of this kind (a matter I refrain from entering into), counsel's contention seems to me to go beyond the kind of protection s. 7 was intended to afford. All s. 7 does is give a remedy to protect individuals against laws or other state action that deprive them of liberty. It has no application here.[388]

Although the Court did not find it necessary to rely on the *Charter* in deciding the case, it emphasized the fundamental nature of the right to procreate. Justice La Forest pointed out the "growing legal recognition of the fundamental character of the right to procreate,"[389] "the great privilege of giving birth"[390] and "[t]he importance of maintaining the physical integrity of a human being . . . particularly as it affects the privilege of giving life."[391] He characterized the proposed sterilization as a "grave intrusion on a person's rights"[392] and an "irreversible and serious intrusion on the basic rights of the individual."[393]

In conclusion, Canadian courts have not yet addressed the question of whether the right to liberty and the right to security of the person guaranteed by section 7 entail a right to procreate. However, in light of the expansive definition of liberty advanced by Justice Wilson, the influence of U.S. jurisprudence, and the strong language of Justice La Forest in the *Eve* case underlying the importance to an individual of the ability to procreate, it seems likely that either liberty or security of the person, or both, will be found in a future case to include the right to procreate.

2. The Deprivation of Liberty or Security of the Person and the Principles of Fundamental Justice

As noted above, establishing a violation of section 7 involves a two-step process. First, one must establish that there has been an interference with life, liberty or security of the person and, second, one must show that the interference is not in accordance with the

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387. *Ibid.* at 436.

388. *Ibid.*

389. *Ibid.* at 419-20.

390. *Ibid.* at 428.

391. *Ibid.* at 434.

392. *Ibid.* at 431.

393. *Ibid.* at 432. The English courts reached the same conclusion in a case involving a fact situation similar to that in *Eve*. In *Re D (a minor)*, [1976] 1 All E. R. 326 at 332, the Court stated:

> The type of operation proposed is one which involves the deprivation of a basic human right, namely the right of a woman to reproduce, and therefore it would, if performed on a woman for non-therapeutic reasons and without her consent, be a violation of such right.

principles of fundamental justice. Assuming that the courts do hold that the right to liberty or security of the person entails a right to procreate, legislation limiting access to reproductive technologies will not necessarily violate section 7. That will only be the case if the legislative limits are imposed in a manner that violates the principles of fundamental justice.

The principles of fundamental justice have both a procedural and a substantive component.[394] In their procedural aspect, the principles of fundamental justice are similar to common law notions of procedural fairness. As Justice Wilson put it in *Singh*, procedural fairness means that:

> [T]he tribunal which adjudicates upon [a person's] rights must act fairly, in good faith, without bias and in a judicial temper, and must give to him the opportunity to adequately state his case.[395]

This means that persons seeking to exercise their right to procreate through the use of a reproductive technology must be treated in a procedurally fair manner by any law limiting access to that technology. The operation of the administrative structure must not be unfair or arbitrary,[396] and the criteria determining accessibility must not be vague.[397] An applicant who is initially denied access must be granted an opportunity to defend his or her rights.[398] The applicant must be made aware of the reasons for the denial of access prior to the hearing, and at the hearing the applicant must be given an adequate opportunity to state his or her case. It should be noted, however, that an oral hearing will not be necessary in cases in which credibility is not at issue. As Justice Wilson stated in *Singh*:

> I am prepared to accept [the] submission that procedural fairness may mean different things in different contexts. . . . Thus it is possible that an oral hearing before the decision-maker is not required in every case in which s. 7 of the *Charter* is called into play. . . .
>
> I should note, however, that even if hearings based on written submissions are consistent with the principles of fundamental justice for some purposes, they will not be satisfactory for all purposes. In particular, I am of the view that where a serious issue of credibility is involved, fundamental justice requires that credibility be determined on the basis of an oral hearing.[399]

According to the Supreme Court, the substantive aspects of the principles of fundamental justice

> are to be found in the basic tenets of our legal system. They do not lie in the realm of general public policy but in the inherent domain of the judiciary as guardian of the justice system.[400]

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394. *Reference re Section 94(2) of the* Motor Vehicle Act *(B.C.)*, *supra*, note 337 at 497-99.

395. *Supra*, note 336 at 213, quoting *Duke* v. *The Queen*, [1972] S.C.R. 917 at 923.

396. See *Morgentaler*, *supra*, note 336.

397. *Ibid.*

398. See *Singh*, *supra*, note 336.

399. *Ibid.* at 213-14.

400. *Reference re Section 94(2) of the* Motor Vehicle Act *(B.C.)*, *supra*, note 337 at 503.

An example of such a principle is the notion that the morally innocent shall not be punished; any law that has the potential of depriving the morally innocent of their liberty will accordingly violate section 7.[401]

The substantive aspects of the principles of fundamental justice enable the courts to go beyond the examination of the fairness of the administration of the law to an evaluation of the substance of the legislation to determine whether it complies with "the basic tenets of our legal system." This appears to require the courts to pass judgment on the wisdom of a legislative policy that interferes with life, liberty or security of the person, a task that courts prefer to leave to the legislature. Accordingly, this is a branch of section 7 review that the courts are likely to apply with some caution.[402] Thus far the Court has not developed any substantive principles of fundamental justice outside the context of criminal procedure.

As long as any restrictions on access to reproductive technologies are not arbitrary,[403] it is unlikely that such restrictions would conflict with substantive principles of fundamental justice. The Court has stated that the future growth of the principles of fundamental justice will be based on "historical roots"[404] that "have been developed over time as presumptions of the common law" or "have found expression in the international conventions on human rights" or "have been recognized as essential elements of a system for the administration of justice which is founded upon a belief in 'the dignity and worth of the human person' and on 'the rule of law'."[405] An unrestricted right of access to the means necessary to procreate does not have such privileged roots in our legal traditions.

B. The Application of Section 7 to Certain Aspects of Medically Assisted Procreation

In light of the above general discussion of the principles governing the interpretation of section 7, we will now turn to the more specific issues raised by surrogate motherhood and access to medically assisted procreation.

1. The Enforceability of Surrogacy Contracts

In this section we will consider whether legislation rendering surrogacy contracts enforceable or unenforceable, or regulating the circumstances in which such contracts would be enforceable in court, would interfere with rights protected by section 7 of the *Charter*.

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401. *Ibid.*; *R.* v. *Vaillancourt*, [1987] 2 S.C.R. 636.

402. See the comments of Dickson C.J. in *Morgentaler*, *supra*, note 336 at 53.

403. See, *e.g.*, *R.* v. *Beare*; *R.* v. *Higgins*, [1988] 2 S.C.R. 387.

404. *Reference re Section 94(2) of the* Motor Vehicle Act *(B.C.)*, *supra*, note 337 at 513.

405. *Ibid.* at 503.

The only case that discusses the relationship between a constitutional right to procreate and the enforceability of surrogacy contracts is the U.S. case of *Baby M*,[406] which arose out of the competing claims of the biological mother and father in a dispute over the custody of a child conceived in performance of a surrogacy contract. The biological father, Mr. Stern, argued that the right to procreate included the right to enforce a surrogacy contract. In holding that he had a constitutional right to custody of the child, the lower court reasoned as follows:

> [I]f one has a right to procreate coitally, then one has the right to reproduce non-coitally. If it is the reproduction that is protected, then the means of reproduction are also to be protected. The values and interests underlying the creation of family are the same by whatever means obtained. This court holds that the protected means extends to the use of surrogates. . . . It might even be argued that refusal to enforce these contracts and prohibition of money payments would constitute an unconstitutional interference with procreative liberty since it would prevent childless couples from obtaining the means with which to have families. . . . A woman and her husband have the right to procreate and rear a family. The means to do so can be withheld from them only on a showing of a compelling state interest.[407]

The Court therefore held that the rights of the parties under the surrogate contract were constitutionally protected. On appeal, the New Jersey Supreme Court rejected this reasoning, holding that:

> The right to procreate very simply is the right to have natural children, whether through sexual intercourse or artificial insemination. It is no more than that. Mr. Stern has not been deprived of that right. . . . The custody, care, companionship, and nurturing that follow birth are not parts of the right to procreation. . . . To assert that Mr. Stern's right of procreation gives him the right to the custody of Baby M would be to assert that Mrs. Whitehead's right of procreation does *not* give her the right to the custody of Baby M; it would be to assert that the constitutional right of procreation includes within it a constitutionally protected contractual right to destroy someone else's right of procreation. . . . There is nothing in our culture or society that even begins to suggest a fundamental right on the part of the father to the custody of the child as part of his right to procreate when opposed by the claim of the mother to the same child.[408]

The *Baby M* decision is in accord with the earlier case of *Doe* v. *Kelley*,[409] a challenge to a Michigan adoption statute that prohibited the exchange of money or other consideration in connection with an adoption or related proceedings. A couple sought to engage in a surrogacy arrangement and to rely on an adoption proceeding to secure their legal right to the child. The court found that the statute did not violate the couple's right to procreate:

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406. 525 A. 2d 1128 (N.J. Super. Ch. 1987).

407. *Ibid.* at 1164-65. See the criticisms of this reasoning in Laurence A. Tribe, *American Constitutional Law*, 2d ed. (Mineola, N.Y.: Foundation, 1988) at 1360-62.

408. *Baby M*, *supra*, note 302 at 1253-54. See the criticism in Robertson, *supra*, note 382 at 23-24.

409. *Supra*, note 310.

> The statute in question does not directly prohibit John Doe and Mary Roe from having the child as planned. It acts instead to preclude plaintiffs from paying consideration in conjunction with their use of the state's adoption procedures. In effect, the plaintiffs' contractual agreement discloses a desire to use the adoption code to change the legal status of the child — *i.e.*, its right to support, intestate succession, etc. We do not perceive this goal as within the realm of fundamental interests protected by the right to privacy from reasonable government regulation.[410]

Robertson has disputed these courts' claim that the right to procreate does not "includ[e] within it a constitutionally protected contractual right to destroy someone else's right of procreation."[411] He argues that the parties to a surrogacy arrangement should have the freedom of contract to dispose of their constitutional rights as they see fit:

> A strong argument based on the autonomy of couples and surrogates can be made that the preconception agreement of the parties, which made the very existence of the child possible, should prima facie be determinative, just as it would be with sperm or egg donors. . . . It simply is unclear why [the] agreement, if knowingly and freely made, should not control in [the] circumstances.[412]

In the Canadian context, the argument that the biological father has a right under section 7 of the *Charter* to enforce a surrogacy contract depends on a number of problematic propositions: first, that the right to procreate entails custody rights once the child is born; second, that denying the father custody of the child would violate the principles of fundamental justice; and, finally, that the biological mother is free to contractually waive her own constitutional right to procreate (to the extent that it too would entail a right to custody of the child) and that she is not free to revoke that waiver when the child is born.

On the other hand, a biological mother's claim to a constitutional right to retain custody of the child conceived in performance of a surrogacy agreement would also depend upon the assertion of a number of problematic propositions: first, that the right to procreate entails a right to custody once the child is born; second, that denying her custody of the child would violate the principles of fundamental justice; and, finally, that a pre-conception contractual agreement to turn over the child is an ineffective waiver of her constitutional rights.

As far as the right to custody is concerned, an argument can be made that the right to procreate is an empty one if the state permits a child to be taken from its parents at birth.[413] However, there are obvious difficulties in superimposing a constitutional framework on the competing claims made by parties to custody disputes. Our law gives primacy to the best interests of the child rather than to the alleged *Charter* rights of the parents.

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410. *Ibid.* at 441.

411. Robertson, *supra*, note 382 at 23; see also *Baby M*, *supra*, note 302 at 1254.

412. Robertson, *supra*, note 382 at 23-24.

413. *Ibid.* at 23: "[R]earing [is] the result that makes conception itself so worthy of protection. . . . Mr. Stern's interest in hiring a surrogate is precisely to conceive a child whom he will then rear."

It is not surprising that courts have been reluctant to allow the *Charter* to add further procedural complexity to child-protection and custody disputes.[414]

Even assuming the biological parents could each assert a constitutional right to custody, we would nonetheless be left with reciprocal, competing constitutional claims, as in the *Baby M* case.[415] It has been argued that the way out of this deadlock is to allow the contractual determination of rights to prevail: the biological father's constitutional claim would prevail because the biological mother waived her constitutional rights when she entered into the surrogacy agreement.[416]

The Supreme Court of Canada has in fact held that individuals are free to waive their constitutional rights.[417] The Court has stated that an individual "cannot be compelled to take advantage of rights for his or her benefit even if such rights may have a public interest aspect."[418] To be effective, however, any waiver of rights must be voluntary, and it "must be premised on a true appreciation of the consequences of giving up the right."[419] On this test, the question is whether a biological mother, at the time of entering into a surrogacy contract, could ever have a "true appreciation" of the emotional difficulty she might experience in surrendering the child to the biological father. Another difficulty is that a biological mother seeking to retain custody of the child is clearly no longer *freely* waiving her alleged constitutional rights. It is not clear that a waiver of constitutional rights would be effective if it is subsequently revoked in these circumstances.

At present, surrogacy contracts are probably unenforceable in civil and at common law as being contrary to public policy,[420] although the issue has yet to be tested in a Canadian court. Recent legislation in England has rendered surrogacy arrangements unenforceable and prohibited all commercial agreements,[421] a development in line with the recommendations of most of the studies carried out in this area.[422] As Knoppers and Sloss have pointed out:

> These recommendations are based on the negative psychological and emotional implications for the gestational mother on having to give up a child she carried to term, the repugnance of contracting to surrender parental rights, and the potential of commercial exploitation of such arrangements (which one British report has equated with prostitution).[423]

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414. See *Re T and Catholic Children's Aid Society*, *supra*, note 368; *Re McTavish and Director, Child Welfare Act* (1986), 32 D.L.R. (4th) 394 (Alta Q.B.).

415. *Supra*, note 302.

416. See Robertson, *supra*, note 382.

417. See *Clarkson* v. *The Queen*, [1986] 1 S.C.R. 383 at 396 (right to counsel cannot be forced upon an unwilling accused); *R.* v. *Turpin*, [1989] 1 S.C.R. 1296 (waiver of right to a jury trial).

418. *Turpin*, *supra*, note 417 at 1316.

419. *Clarkson*, *supra*, note 417 at 396.

420. See "Legality and Legitimacy," *supra* at 65.

421. See the *Human Fertilisation and Embryology Act 1990* (U.K.), 1990, c. 37, s. 36, and the *Surrogacy Arrangements Act 1985* (U.K.), 1985, c. 49, s. 2, following the recommendations of the *Report of the Committee of Inquiry into Human Fertilisation and Embryology* (London: HMSO, 1984) at 47 (Chair: Dame Mary Warnock) [hereinafter Warnock Report].

422. For more details, see appendix A, *infra* at 173.

423. *Supra*, note 269 at 709.

If legislation were passed to make clear that surrogacy contracts were legally unenforceable, it is unlikely that the courts would find a violation of section 7 of the *Charter*. Even assuming that any such legislation would be found to constitute an interference with liberty because of the burden on the right to procreate of men with infertile partners, and assuming also that the courts would hold that the biological mother is free to contractually waive her constitutional rights, restrictions on conception arrangements involving a consideration would not violate the principles of fundamental justice.

Rendering surrogacy contracts unenforceable is consistent with two fundamental principles of existing family law. The first is that custody of children be determined in accordance with the best interests of the child rather than the contractually expressed wishes of the parents. The primacy placed on the best interests of the child over freedom of contract is evident in family law legislation that prohibits parties from dealing with custody or access to children in marriage contracts or cohabitation agreements,[424] and that empowers a court to disregard any provision of a domestic contract pertaining to the support, education, moral training, custody of or access to a child if it is in the best interests of the child to do so.[425] Second, it is illegal to receive payment in return for arranging the adoption of a child.[426] Such legislation, far from violating the fundamental tenets of the Canadian legal system, is consistent with those tenets.

In summary, there are many legal obstacles in the way of the argument that custody disputes following the birth of a child to a surrogate can be resolved by recourse to section 7 of the *Charter*. It seems likely that any legislation passed in this area, whether it renders surrogacy contracts enforceable or unenforceable, will not offend the section 7 rights of either biological parent.

2. In Vitro Fertilization

The theory that the right to procreate entails a right of access to IVF technology was argued before a U.S. federal court, but the judgment left the issue unresolved. In *Smith* v. *Hartigan*,[427] an infertile couple alleged that an Illinois statute rendered in vitro fertilization illegal and thus "infringe[d] on their privacy interests because the provision prevent[ed] them from effectuating their only hope for conceiving a child."[428] While the defendant attorney general conceded that the "plaintiffs' situation presents the strongest case for a fundamental right to [in vitro fertilization],"[429] the court found it unnecessary to address the constitutional issue, it having held that the statute did not prohibit in vitro fertilization in the circumstances.

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424. See, *e.g.*, ss 52(1)(c) and 53(1)(c) of the Ontario *Family Law Act, 1986*, *supra*, note 196.

425. *Ibid.*, s. 56(1).

426. See *supra* at 67ff.

427. 556 F. Supp. 157 (1983).

428. *Ibid.* at 160.

429. *Ibid.* at 161.

It is not possible to predict whether a Canadian court would interpret the right to procreate to include access to IVF services. It may be that the right to procreate will be limited to natural procreation only, or extended no further than to include artificial insemination. Nevertheless, the prudent course would appear to be to assume that access to IVF might be held to fall within the scope of section 7 of the *Charter*.

Even were a court to so conclude, it would not mean that access to IVF could not be limited or regulated. Canadian case law suggests that the guarantee of *Charter* rights and freedoms does not impose affirmative obligations on governments to initiate laws or programs, because prior government action is necessary to invoke the *Charter*.[430] Thus, the government has no obligation to initiate the provision of IVF services. But were the government to pass legislation restricting access to existing IVF services, then the necessary government action would be present and the right to procreate of infertile women and their partners could be found by a court to have been violated. If so, any such legislative restriction would have to be in accordance with the principles of fundamental justice.

It is difficult to predict what procedures a court would require to comply with the principles of fundamental justice in such a case. At the very least, fundamental justice would require that access to IVF services be determined in accordance with fair and rational criteria that are communicated to applicants. Furthermore, fundamental justice would require that applicants for IVF services be treated in a procedurally fair manner, and given an opportunity to present their case fully in their application for access. It is unlikely that a court would insist that there be an oral hearing at this stage, as long as the criteria are clear and no issues of credibility are raised.[431] It is even more difficult to predict whether in this context fundamental justice would require that there be a system of appeal from decisions denying access to IVF services.[432]

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430. See, *e.g.*, *RWDSU* v. *Dolphin Delivery Ltd.*, *supra*, note 333. However, where government has initiated a program on a limited basis, a remedy can be obtained under the *Charter* ordering the extension of benefits or services in a manner consistent with s. 15 equality rights. See, *e.g.*, *Schachter* v. *Canada*, *infra*, note 564.

    Some sections of the *Charter*, such as the language rights in ss 16-23, do expressly create entitlements to a particular government service and may thus be invoked in the absence of government action; however, those sections are not relevant to the present discussion of the right to procreate.

431. See *Singh*, *supra*, note 336.

432. *Ibid.* In *Singh*, where the threat to liberty arose from the possibility of persecution (or even death) on the return of refugee applicants to their home country, the Supreme Court stated that fundamental justice required that a right of appeal be granted. In our view, the degree of interference with the liberty interest of an applicant for IVF services is not as extensive as was the case in *Singh*. Since the procedural protection required by s. 7 will vary with the degree of interference with the liberty interest, it may well be that a court would find an appeal right unnecessary in this context.

3. Artificial Insemination (AI)

The only reported cases dealing with AI involve the issue of the child's parentage.[433] In the only constitutional challenge to a possible restriction of AI to exclude single women, the Michigan chapter of the American Civil Liberties Union filed a complaint on behalf of a single woman who was refused AI, but the case was settled when the clinic accepted the woman's application.[434]

AI is unlike IVF in that minimal or non-existent technological requirements, public expense or medical complications are involved. The procedure can be performed very simply in the privacy of one's home without the intervention of experts. And unlike surrogacy, the involvement of the genetic donor is not an ongoing one: the genetic donor's involvement in the process is often over once he has made his contribution of semen. For these reasons, attempts to regulate the performance of AI raise serious privacy concerns that are not present with the other techniques of non-coital procreation. Just as regulation "is neither desirable nor practicable in the case of natural reproduction,"[435] it may be argued that the state has no place in the bedroom of a woman attempting to artificially inseminate herself. Regulation of such private behaviour would constitute an interference with liberty and might, it may be argued, infringe the principles of fundamental justice. A basic tenet of our legal system is the principle of non-interference in private behaviour that causes no harm to others.

Regulation of sperm banks or of the medical performance of AI does not raise such privacy concerns. The purpose of such regulation would be to ensure that genetic and other health problems are avoided. Ensuring the safety of the AI procedure in this way would not raise constitutional objections.

4. The Right to Be Informed of One's Biological Origins

The issue to be addressed in this section is whether a child conceived by means of medically assisted procreation has a constitutional right to information regarding his or her genetic origins.

The psychological need to know one's biological roots has gained increasing recognition in the context of adoption, and a growing number of adoptees have been pressuring courts and legislatures to relax the closed-record policies traditionally followed by adoption

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433. *C.M.* v. *C.C.*, 377 A. 2d 821 (1977) (known donor has parental rights); *Jhordan C.* v. *Mary K.*, 179 Cal. App. 3d 386 (1986) (donor is child's father).

434. *Snede* v. *Wayne State Univ.* (15 July 1980), E.D. Mich. 80-725-83. See Patricia A. Kern and Kathleen M. Ridolfi, "The Fourteenth Amendment's Protection of a Woman's Right to Be a Single Parent through Artificial Insemination by Donor" (1982) 7 Women's Rights L. Rep. 251 at 254 n. 22 for a description of the plaintiff's brief in this case.

435. OLRC, *supra*, note 2 at 154.

agencies.[436] Recent studies have recognized that the disclosure of information to an adult adoptee is desirable as long as such disclosure does not conflict with the birth parents' right to withhold identifying information if they so desire. It was recommended that the right of a birth parent or the donor of genetic material to remain anonymous should prevail over the child's right to be informed.[437]

In the United States, constitutional challenges to closed-adoption-record laws on the grounds that adoptees have a fundamental right to know their biological origins have not succeeded. The courts have generally held that closed-record laws achieve a desirable balance between the birth parents' privacy rights, the state's interest in protecting the integrity of the adoption process, and the adoptees' need for information.[438]

Section 7 of the *Charter* requires that a distinction be drawn between information that discloses the identity of the biological parents and that which does not. The release of non-identifying genetic and medical information is often necessary to the physical well-being of the child conceived through medically assisted procreation. The majority in *Morgentaler*[439] recognized that security of the person included a right of access to medical treatment for a condition that represents a danger to life or health. Refusal to disclose information necessary to the preservation of life and health would similarly interfere with the security of the person conceived by means of medically assisted procreation. Legislation that provided for the automatic release of non-identifying information would protect the interests of the person so conceived without compromising the privacy rights of donors.

On the other hand, the disclosure of identifying information raises a clear conflict between the interests of the child in knowing the identity of his or her biological parents and the interests of donors in remaining anonymous. Many donors participate in medically assisted procreation programs on condition that they remain anonymous. Provisions for

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436. Knoppers, *supra*, note 260; Ontario, Ministry of Community and Social Services, *Ontario's New Adoption Disclosure Policy* (Toronto: Queen's Printer for Ontario, 1986); *Background Paper on the Establishment of an Adult Adoption Disclosure Registry in British Columbia* (Victoria, B.C.: Ministry of Social Services and Housing, 1986); Community Task Force on Maternal and Child Health, *Adoption: Acquisition and Disclosure of Records* (Winnipeg, Man.: The Task Force, 1981); Manitoba Law Reform Commission, *Working Paper on Confidentiality of Adoption Records* (Winnipeg, Man.: The Commission, 1979); Barreau du Québec, *Mémoire du Comité du Barreau du Québec sur la confidentialité des dossiers d'adoption et la recherche des antécédents* (Montreal: The Bar, 1986); Clare Marcus, *Adopted? A Canadian Guide for Adopted Adults in Search of Their Origins* (Vancouver, B.C.: International Self-Counsel Press, 1979).

437. See Knoppers, *supra*, note 260.

438. See *Alma Society Incorporated* v. *Mellon*, 601 F. 2d 1225 (1979); *Re Roger B.*, 84 Ill. 2d 325 (1981); Debra D. Poulin, "The Open Adoption Records Movement: Constitutional Cases and Legislative Compromise" (1987-88) 26 J. Fam. L. 395; Heidi A. Schneider, "Adoption Contracts and the Adult Adoptee's Right to Identity" (1988) 6 Law & Inequality 185; Carolyn Burke, "The Adult Adoptee's Constitutional Right to Know His Origins" (1975) 48 S. Cal. L. Rev. 1196; Marilee C. Unruh, "Adoptee's Equal Protection Rights" (1981) 28 U.C.L.A. L. Rev. 1314.

439. *Supra*, note 336.

the disclosure of identifying information would therefore jeopardize the operation of programs and interfere with the privacy interests of donors. In the face of these equally compelling competing claims, section 7 would not be violated by legislation that prohibited the disclosure of identifying information without the consent of the donor.[440]

C. Section 15 Equality Rights

Section 15 provides, in part, as follows:

> 15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

A framework for the analysis of equality claims was set out recently by the Supreme Court in *Andrews* v. *Law Society of British Columbia*.[441] Justice McIntyre, writing for a majority of the Court on the interpretation of subsection 15(1), expressed the goal of section 15 as follows:

> [T]he admittedly unattainable ideal should be that a law expressed to bind all should not because of irrelevant personal differences have a more burdensome or less beneficial impact on one than another.[442]

As is the case for section 7, to establish a violation of section 15 one must follow a two-step process: first, one must establish a violation of one of the four basic equality rights guaranteed by section 15,[443] and second, one must establish that the impact of the law is discriminatory.[444]

The Court has defined the "minimal content of the right to equality before the law" as follows:

> The guarantee of equality before the law is designed to advance the value that all persons be subject to the equal demands and burdens of the law and not suffer any greater disability in the substance and application of the law than others.[445]

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440. Most recent reports on both adoption and medically assisted procreation have recommended that non-identifying information be made readily available and that identifying information be released only with the consent of the biological parent. See Knoppers and Sloss, *supra*, note 269 at 693-96; Knoppers, *supra*, note 260 at 832-33; Ontario, Ministry of Community and Social Services, *supra*, note 436.

441. [1989] 1 S.C.R. 143.

442. *Ibid.* at 165.

443. *Turpin*, *supra*, note 417. A litigant must show that he or she is not receiving equal treatment before or under the law or that the law has a differential impact on him or her in the protection or benefit accorded by the law.

444. *Andrews*, *supra*, note 441 at 182.

445. *Turpin*, *supra*, note 417 at 1329.

With respect to the concept of discrimination, in the *Andrews* decision Justice McIntyre referred to and adopted the following definition of discrimination from the *Action Travail des femmes* case:

> Discrimination . . . means practices or attitudes that have, whether by design or impact, the effect of limiting an individual's or a group's right to the opportunities generally available because of attributed rather than actual characteristics. . . .
>
> It is not a question of whether this discrimination is motivated by an intentional desire to obstruct someone's potential, or whether it is the accidental by-product of innocently motivated practices or systems. If the barrier is affecting certain groups in a disproportionately negative way, it is a signal that the practices that lead to this adverse impact may be discriminatory.[446]

Justice McIntyre then proposed the following definition of discrimination:

> [D]iscrimination may be described as a distinction, whether intentional or not but based on grounds relating to personal characteristics of the individual or group, which has the effect of imposing burdens, obligations, or disadvantages on such individual or group not imposed upon others, or which withholds or limits access to opportunities, benefits, and advantages available to other members of society. Distinctions based on personal characteristics attributed to an individual solely on the basis of association with a group will rarely escape the charge of discrimination, while those based on an individual's merits and capacities will rarely be so classed.[447]

Not every legislative distinction will constitute discrimination. The Supreme Court has made it clear that only laws that have an unequal impact on groups of persons having in common any of the characteristics that constitute an enumerated or analogous ground can constitute discrimination for the purpose of section 15. A law that has an unequal impact on persons who cannot be associated with a group contemplated in section 15 cannot be considered discriminatory. The Court emphasized that the test for the eligibility of a group for section 15 protection lay in a situation of social, political or legal disadvantage related to a ground analogous to those enumerated in section 15. In *Andrews*, the Court stressed that non-citizens lack political power, have suffered a history of discrimination, and therefore constitute a good example of a discrete and insular minority deserving of section 15 protection.

On the other hand, in *Reference Re* Workers' Compensation Act, 1983 *(Nfld)*,[448] the Court summarily dismissed a challenge to a workers' compensation statute that denied access to the courts to victims of workplace accidents and their dependents. The court was unanimously of the view that the statute did not create any discrimination within the meaning of section 15, since

> [t]he situation of the workers and dependents here is in no way analogous to those listed in s. 15(1), as a majority in *Andrews* stated was required to permit recourse to s. 15(1).[449]

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446. *Andrews*, *supra*, note 441 at 174, quoting from *Canadian National Railway Co.* v. *Canada (Canadian Human Rights Commission)*, [1987] 1 S.C.R. 1114 at 1138-39.

447. *Andrews*, *supra*, note 441 at 174-75.

448. [1989] 1 S.C.R. 922.

449. *Ibid.* at 924.

Similarly, in *Turpin*[450] the Court rejected a challenge by accused persons outside the province of Alberta to a provision of the *Criminal Code* that provided accused persons in Alberta, but not elsewhere, the right to choose to have a trial by judge alone. Speaking for the Court, Justice Wilson rejected the claim on the grounds that accused persons outside Alberta did not constitute an analogous group for the purposes of section 15:

> [I]t would be stretching the imagination to characterize persons accused of one of the crimes listed in s. 427 of the *Criminal Code* in all the provinces except Alberta as members of a "discrete and insular minority." ... Differentiating for mode of trial purposes between those accused of s. 427 offences in Alberta and those accused of the same offences elsewhere in Canada would not, in my view, advance the purposes of s. 15 in remedying or preventing discrimination against groups suffering social, political and legal disadvantage in our society. A search for indicia of discrimination such as stereotyping, historical disadvantage or vulnerability to political and social prejudice would be fruitless in this case because what we are comparing is the position of those accused of the offences listed in s. 427 in the rest of Canada to the position of those accused of the offences listed in s. 427 in Alberta. ... Persons resident outside Alberta and charged with s. 427 offences outside Alberta do not constitute a disadvantaged group in Canadian society within the contemplation of s. 15.[451]

It follows that any attempt to regulate access to reproductive technologies by the use of rules that would have a disparate impact on an enumerated or analogous group would violate section 15. Conversely, rules that have a disparate impact on groups not analogous to the enumerated groups would not be discriminatory for the purposes of section 15. For example, an argument by an infertile couple that a rule limiting access to reproductive technologies discriminates against the infertile as a class is not likely to succeed. The infertile do not constitute a discrete and insular minority that have suffered a history of disadvantage or a lack of political power.[452]

On the other hand, rules that discriminate or have a disparate impact on groups with respect to an enumerated ground such as sex, or an analogous ground such as marital status, parental status,[453] family status or sexual orientation, will be vulnerable to a section 15 challenge.

One of the clearest examples of a non-enumerated, but nevertheless protected, ground of discrimination is marital status. It is a ground of discrimination expressly prohibited

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450. *Supra*, note 417.

451. *Ibid.* at 1333.

452. It may be that rules will impose an unequal burden on a subset of the group of infertile people defined by their sex, class, marital status or sexual orientation. In that case, the possibility of making out a case of discrimination on a prescribed ground arises. See Martha A. Field, *Surrogate Motherhood*, expanded ed. (Cambridge, Mass.: Harvard University Press, 1990) at 47-49 for a discussion of these issues.

453. For an example of discrimination on the basis of parental status, see *Symes* v. *Canada*, [1989] 3 F.C. 59 at 81-82 (T.D.). It should be noted that the trial decision was reversed on other grounds (19 June 1991) A-290-89 (C.A.).

by human rights legislation in every Canadian jurisdiction.[454] In addition, family status is a prohibited ground of discrimination in federal legislation, and in Manitoba,[455] Ontario[456] and the Northwest Territories.[457] Discrimination against an individual based on his or her status as a single, married, divorced or widowed person is prohibited. Case law interpreting these legislative human rights guarantees has increasingly affirmed the principle that rules cannot be based on distinctions drawn upon stereotypical characteristics associated with the family status of an individual without a consideration of his or her actual situation or merits as they relate to the benefit or service at issue.[458]

It is generally recognized that marital and family status are grounds of discrimination that ought to be recognized under section 15 of the *Charter*. For example, the Parliamentary Committee on Equality Rights concluded as follows:

> We believe that section 15 of the *Charter* should be read against the historical background of the treatment in law of married women and the recognition nationally and internationally that marital and, in many cases, family status deserve protection by the state. Accordingly, while section 15 does not specifically prohibit discrimination on the basis of marital or family status, we believe that the ground can be properly read into the open-ended language of the section. In other words, marital or family status is implicitly covered by section 15.[459]

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454. *Canadian Human Rights Act*, S.C. 1976-77, c. 33; *Fair Practices Act*, R.S.N.W.T. 1988, c. F-2; *Human Rights Act*, S.Y.T. 1987, c. 3, s. 6 (k); *Human Rights Act*, S.B.C. 1984, c. 22; *Individual Rights Protection Act*, R.S.A. 1980, c. I-2; *The Saskatchewan Human Rights Code*, S.S. 1979, c. S-24.1, s. 12(1); *The Human Rights Code*, S.M. 1987-88, c. 45, s. 9(2)(i); *Human Rights Code, 1981*, S.O. 1981, c. 53, s. 1; Quebec Charter, *supra*, note 255, s. 10 ("civil status"); *Human Rights Act*, R.S.N.B. 1973, c. H-11; *Human Rights Act*, R.S.N.S. 1989, c. 214, s. 12(2); *Human Rights Act*, R.S.P.E.I. 1988, c. H-12; *The Human Rights Code*, S.N. 1988, c. 62. See generally A. Anne McLellan, "Marital Status and Equality Rights" in Anne F. Bayefsky and Mary Eberts, eds, *Equality Rights and the Canadian Charter of Rights and Freedoms* (Toronto: Carswell, 1985) at 411.

455. *The Human Rights Code*, *supra*, note 454, s. 9(2)(i).

456. Ontario defines family status to mean "the status of being in a parent and child relationship." *Human Rights Code, 1981*, *supra*, note 454, s. 9(1)(d).

457. *Fair Practices Act*, *supra*, note 454.

458. *Brossard (ville)* v. *Québec (Commission des droits de la personne)*, [1988] 2 S.C.R. 279 at 298 (municipality's blanket anti-nepotism policy discriminated on the basis of civil status); *Cashin* v. *Canadian Broadcasting Corporation*, [1988] 3 F.C. 494 (C.A.); *Saskatchewan Human Rights Commission* v. *Saskatchewan (Department of Social Services)* (1988), 52 D.L.R. (4th) 253 (Sask. C.A.) (lower welfare benefits to single persons constitutes discrimination on the basis of marital status under the provincial human rights code); *Schaap* v. *Canadian Armed Forces*, [1989] 3 F.C. 172 at 184 (C.A.), Hugessen J.: employer's policy of granting family accommodation only to married couples

> perpetuates a stereotype, namely, that a relationship between a man and a woman has a lesser social value if it does not have the status of marriage. . . . It is a commonplace that the existence of the marriage bond is no guarantee of the permanency and stability of a relationship, just as its absence is no sure indicator of a mere passing fancy.

See, however, *Canada (Attorney General)* v. *Mossop*, [1990] 1 F.C. 18 (C.A.), rev'g *Mossop* v. *Canada (Secretary of State)* (1989), 10 C.H.R.R. D/6064.

459. Canada, House of Commons, Sub-committee on Equality Rights, *Equality for All: Report of the Parliamentary Committee on Equality Rights* (Ottawa: Queen's Printer, 1985) at 34 (Chair: J. Patrick Boyer).

In *Re MacVicar and Superintendent of Family and Child Services*,[460] the Court concluded that discrimination on the basis of marital status was prohibited by the *Charter*:

> Marital status is a direct result of a personal decision whether or not to marry with the blessing of the State and thereby obtain certain rights and incur certain obligations. . . . Marital status, in itself, bears no relationship to ability to nurture a child and consider its best interest.[461]

Similarly, there is a growing recognition of the need to provide legal recognition of the rights of sexual minorities.[462] The Parliamentary Committee on Equality Rights concluded that "'sexual orientation' should be read into the general open-ended language of section 15 of the *Charter* as a constitutionally prohibited ground of discrimination."[463] Sexual orientation is a ground of discrimination not enumerated in section 15, but is analogous to the enumerated grounds in that gay men and lesbian women constitute discrete and insular minorities that have suffered a history of discrimination.[464] Sexual orientation is now a prohibited ground of discrimination in Quebec, Ontario, Manitoba and the Yukon.[465]

In sum, there is little doubt that any legislative limitations placed on access to reproductive technologies will have to be tailored to avoid discrimination on the basis of family status, marital status and sexual orientation. On the other hand, legislation requiring applicants to be assessed on the basis of their merits and capacities as potential parents would not violate section 15. Such an approach would also be in line with current Canadian adoption law and the recommendations contained in several provincial reports concerning reproductive technologies. For example, Ontario adoption law has recently been changed

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460. (1986) 34 D.L.R. (4th) 488 (B.C.S.C.).

461. *Ibid.* at 497. See also *M. (N.)* v. *British Columbia (Superintendent of Family and Child Services)* (1986), 10 B.C.L.R. (2d) 234 (S.C.).

462. See James E. Jefferson, "Gay Rights and the *Charter*" (1985) 42 U.T. Fac. L. Rev. 70; Margaret Leopold and Wendy King, "Compulsory Heterosexuality, Lesbians and the Law: The Case for Constitutional Protection" (1985) 1 C.J.W.L. 163; Arnold Bruner, "Sexual Orientation and Equality Rights" in Bayefsky and Eberts, eds, *supra*, note 454 at 457; Philip Girard, "Sexual Orientation as a Human Rights Issue in Canada 1969-1985" (1986) 10 Dalhousie L.J. 267. But see *Andrews*, *supra*, note 441. For a summary of the law in the United States, see Note, "Developments in the Law: Sexual Orientation and the Law" (1989) 102 Harv. L. Rev. 1508. See also Philip Girard, "The Protection of the Rights of Homosexuals under the International Law of Human Rights: European Perspectives" (1986) 3 Can. Hum. Rts Y.B. 3.

463. *Equality for All*, *supra*, note 459 at 29.

464. See Leopold and King, *supra*, note 462; Jefferson, *supra*, note 462; *Watkins* v. *United States Army*, 837 F. 2d 1428 (1988), aff'd 875 F. 2d 699 (1989).

465. Quebec Charter, *supra*, note 255, s. 10; *Human Rights Code, 1981* (Ontario), *supra*, note 454, as am. S.O. 1986, c. 64, s. 18; *The Human Rights Code* (Man.), *supra*, note 454, s. 9(2)(h); *Human Rights Act* (Yukon), *supra*, note 454, s. 6.

to allow for equal consideration of single applicants,[466] as is the case in all other Canadian jurisdictions.[467] Similarly, three recent provincial reports on reproductive technology recognized that limiting access to married couples would violate human rights laws. The Ontario Law Reform Commission concluded that restricting access to reproductive technologies to couples

> would appear to contravene human rights legislation applicable in this Province. Moreover, any *a priori* exclusions based simply on membership in a particular group (such as married persons) would automatically eliminate from consideration single persons or unmarried couples who, by any standard, would make suitable parents.[468]

The Ontario Law Reform Commission accordingly recommended that eligibility to participate in a medically assisted procreation program "should be limited to stable single women and to stable men and stable women in stable marital or nonmarital unions."[469] Similarly, the British Columbia Royal Commission proposed that the guiding standard should be an applicant's "ability to nurture":

> [A]n attempt to judge the recipient in terms of her conformity to prevailing mores about marriage and lifestyle should be made in the context of their current state of flux and, more importantly, should concentrate on the conduct of the individual which can be shown to relate directly to her ability to nurture. As suggested above, the central concern in evaluating the prospective AID recipient should focus directly (and singularly) on her ability to be a successful parent. It is the potential child's interest which must be paramount in this situation.[470]

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466. *Child and Family Services Act, 1984*, *supra*, note 309, s. 140. Previously the law would only allow for the consideration of unmarried applicants in "special circumstances." The change was explained in the background paper to the legislation as follows:

> Aside from a recognition of the changing concepts of marriage and the family, requirements imposed by Ontario's Human Rights Code have contributed to the elimination of the "special circumstances" qualification for unmarried adoptive applicants. Hence, single applicants will be eligible for consideration as adoptive parents. It is, however, anticipated that in most cases adoption practice would continue to reflect a strong preference for a two-parent family based on considerations of the child's best interests.

Ontario, Ministry of Community and Social Services, *The Child and Family Services Act: Draft Legislation and Background Paper* (Toronto: The Ministry, 1983) at 136.

467. *Child Welfare Act* (Alta), *supra*, note 309, s. 56, as am. S.A. 1988, c. 15, s. 35; *Adoption Act* (B.C.), *supra*, note 309, s. 3; *The Child and Family Services Act* (Man.), *supra*, note 309, ss 66(1), 71(1); *Family Services Act* (N.B.), *supra*, note 283, s. 66; *The Adoption of Children Act, 1972* (Nfld), *supra*, note 309, s. 4(1); *Children and Family Services Act* (N.S.), *supra*, note 309, s. 72(1) and (2); *Adoption Act* (P.E.I.), *supra*, note 309, s. 3(1); *C.C.Q.*, arts 598-599; *The Adoption Act* (Sask.), *supra*, note 309, s. 17(2)(b); *Children's Act* (Yukon), *supra*, note 197, s. 79(1).

468. OLRC, *supra*, note 2 at 158.

469. *Ibid.* at 275.

470. British Columbia Royal Commission on Family and Children's Law, *Ninth Report of the Royal Commission on Family and Children's Law: Artificial Insemination* (Vancouver: The Royal Commission, 1975) at 10-11. See also Law Reform Commission of Saskatchewan, *Tentative Proposals for a Human Artificial Insemination Act* (Saskatoon, Sask.: The Commission, 1981) at 1-3:

> [I]t would appear that if a physician or medical institution which generally offers artificial insemination services to the public refuses to inseminate an unmarried woman solely because of her marital status, *The Saskatchewan Human Rights Code* would be violated.

If a limit on access is considered necessary, such an approach, similar to the criteria applied in Canadian adoption law, would be needed to satisfy the requirements of section 15 of the *Charter*. In addition, in light of the definition of discrimination set forth by the Supreme Court,[471] care will have to be taken to ensure that the criteria chosen to regulate access to reproductive technologies do not unjustly burden a group of prospective parents defined by reference to one of the grounds enumerated in section 15 (or a ground analogous to those enumerated in section 15).

For example, let us consider infertility as a potential criterion for access to a reproductive technology. In the case of IVF, legislation making demonstrated infertility a precondition for access would be constitutionally unimpeachable. IVF is a procedure that will mainly be sought by women who are infertile; fertile women can bear children without the assistance of IVF. However, making infertility a precondition for access to surrogate motherhood and AI would give rise to section 15 objections. Such a requirement would impose a disproportionate burden on fertile men and women who wish to exercise their right to procreate non-coitally. These people are defined by their lack of a heterosexual partner, which is to say, by their marital status or their sexual orientation. Legislation imposing infertility as a requirement for access to AI and surrogacy arrangements would effectively deny these men and women the right to procreate. This disproportionate burden suffered by individuals as a result of their marital status or sexual orientation would constitute discrimination for the purposes of section 15.

In addition, care will have to be taken to ensure that criteria neutral on their face in terms of their impact on groups protected by section 15 or analogous groups, such as "ability to parent," are not in practice applied in such a way as to impose an unequal burden on unmarried, single, gay or lesbian applicants for access to reproductive technologies.

D. Section 1

A law that infringed a right or freedom guaranteed in the *Charter* would not be unconstitutional provided that it conformed to the criteria set out in section 1 of the *Charter*. Section 1 provides as follows:

> The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

471. See *Andrews*, *supra*, note 441; *Turpin*, *supra*, note 417.

For a limitation on rights to be upheld, it must be prescribed by law. This requirement was explained by Justice Le Dain in the following terms:

> The requirement that the limit be prescribed by law is chiefly concerned with the distinction between a limit imposed by law and one that is arbitrary. The limit will be prescribed by law within the meaning of s.1 if it is expressly provided for by statute or regulation, or results by necessary implication from the terms of a statute or regulation or from its operating requirements. The limit may also result from the application of a common law rule.[472]

This means that any restrictions on access that would constitute an infringement of the *Charter* must be set out in legislation. Limitations that resulted from the application of policy guidelines or other directives without legal force would not be considered as "prescribed by law" for the purposes of section 1.

With respect to the other requirements of section 1, the basic framework was established by the Supreme Court in *R.* v. *Oakes*.[473] In *Oakes*, the Court held that the legislative objective must be sufficiently important to justify the infringement of rights, and that the means chosen must be reasonable and justified in terms of the objectives sought.

There are certain limitations on the kinds of arguments that courts will entertain under section 1 with respect to such objectives. First, one cannot rely upon a legislative objective that is *ultra vires* Parliament or the legislature or is otherwise itself a violation of the *Charter*.[474] Second, the objective pleaded in justification must be that which actually underlay the legislation, not one that was invented after the fact for the purposes of argument before the courts.[475]

These limitations aside, courts have tended to accept legislative objectives as sufficiently important to justify limitations on rights: most cases turn on the question of whether the limitations on rights were reasonable under the circumstances. In this respect, it is difficult to predict how a court would apply section 1 to any law restricting access to medically assisted procreation. It is now a commonplace to observe that the Supreme Court is divided on the question of how to apply section 1 of the *Charter*, and it is impossible to conclude that section 1 is being applied in a consistent manner.[476] In some cases courts have ruled

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472. *R.* v. *Therens*, [1985] 1 S.C.R. 613 at 645.

473. [1986] 1 S.C.R. 103.

474. *R.* v. *Big M Drug Mart Ltd.*, [1985] 1 S.C.R. 295 at 362 (per Dickson J., as he then was).

475. *Ibid.* at 362.

476. Marc Gold, "Of Rights and Roles: The Supreme Court and the *Charter*" (1989) 23 U.B.C. L. Rev. 507; Robin M. Elliot, "The Supreme Court of Canada and Section 1 - The Erosion of the Common Front" (1987) 12 Queens L.J. 277; Lorraine Eisenstat Weinrib, "The Supreme Court of Canada and Section One of the *Charter*" (1988) 10 Supreme Court L.R. 469.

that government must give compelling reasons for its laws, while in others courts have shown a considerable degree of deference to the legislature.[477] Indeed, recent cases leave unresolved the central question concerning the standard of review to apply in equality rights cases: whether different standards are to apply depending on the nature of the case and, if so, what those standards are.[478] This considerably complicates the task of predicting how a court might apply section 1 to the issues considered in this study.

477. See *R.* v. *Edwards Books and Art Ltd.*, [1986] 2 S.C.R. 713; *Jones*, *supra*, note 336.

478. The division on the Court is clear in *Andrews*, *supra*, note 441. See Marc Gold, "Comment: *Andrews* v. *Law Society of British Columbia*" (1989) 34 McGill L.J. 1063.

CHAPTER THREE

The Role of the State

There is currently no legislation in Canada that deals specifically with medically assisted procreation,[479] but the technologies are subject to other types of control.[480] We must therefore determine the adequacy of these controls before we can decide if legislation in this area is appropriate. Generally speaking, we cannot recommend greater state intervention in medically assisted procreation without considering the role of the state and of the federal government in this field.

I. The Scope of Existing Controls

Among the control mechanisms now in place are individual control based on the parties' individual responsibility and freedom of choice; professional and socio-professional control focusing on the quality of medical practice and the ethical aspects of applying scientific discoveries; community control exercised by permanent ethics committees (provincial and/or national) and the courts; and legislative and regulatory control.

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479. With the exception of provisions in some provinces respecting parentage. See *supra*, chap. 2.

480. See Guy Rocher, "Pour une sociologie des ordres juridiques" (1988) C. de D. 91 at 117-18:

> [TRANSLATION]
> The medical profession has behind it a long tradition of self-regulation. In this respect it is a very old legal order outside the state itself. In the absence of legislation or precedents, the College of Physicians has established its own rules and standards and a code of ethics that serve as law for members of the association. Through ethics committees, disciplinary committees or other means, physicians in hospitals set standards to regulate their conduct and their relations with their patients (and other medical personnel). The medical profession is a typical case of agents or instruments being recognized as having the authority to develop, interpret and enforce rules that have all the characteristics of law but do not originate with the state. . . . Of course, none of this stands in the way of state regulation. What must be considered, then, is the exact source of state regulation: what non-governmental legal order has the credibility, power and influence needed to ensure acceptance of its standards? What compromise will state regulation (by a legislature or a court of law) strike between the standards of several concurrent non-governmental legal orders?

A. Individual Control: The Private Ordering Approach and Individual Responsibility[481]

Absolute priority is given here to individual freedom and the right to privacy. The individuals concerned make their own arrangements and no value-judgment is made regarding their choice. The assessment of the risks and benefits that are part of medically assisted procreation and the decision whether or not to use a technology are left to the free will of the people involved. The role played by lawmakers may be active or passive in that a legislature may specifically entrench freedom of choice in a statute or regulation, or may give tacit approval to such freedom.[482] Without intervening at the outset, it can nevertheless regulate some of the outcomes of private decisions. For example, while it does not become involved in a couple's decision to marry and raise a family, it establishes the property and other rights and obligations of the spouses and the children, as well as the parentage of the children.

This approach has the advantage of focusing on individual responsibility and initiative. It allows every member of a pluralistic society to conduct himself or herself according to his or her own beliefs, without undue interference by the state and without the state imposing a specific set of morals on everyone.[483] It ensures that there is no conflict with the freedom and privacy rights guaranteed by the Constitution and at issue in procreation. The decision to conceive is therefore a purely private one, a moral choice to be left to individuals.[484]

The state does not intervene in natural reproduction.[485] As the Ontario Law Reform Commission has pointed out, the "best interest of the child" is never put forward to justify an intrusion into the private lives of couples or individuals. This criterion was used in the past for eugenic and financial reasons in legislation providing for the forced sterilization of mentally retarded persons, criminals and members of ethnic minorities, but this sort of motivation is no longer considered acceptable;[486] the human rights charters and court rulings guarantee this.

Furthermore, treatment for sterility (hormone therapy, surgery, and so on) is one of the medical services available to the public, and the marital status and psychological profile

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481. See Frances E. Olsen, "The Family and the Market: A Study of Ideology and Legal Reform" (1983) 96 Harv. L. Rev. 1497 at 1504.

482. OLRC, *supra*, note 2 at 106ff.

483. John A. Robertson, "Embryo Research" (1986) 24 U.W.O. L. Rev. 15 at 27.

484. OLRC, *supra*, note 2 at 106ff.; Robertson (1986), *supra*, note 381 at 1040; The American Fertility Society, The Ethics Committee, *supra*, note 187 at 5S.

485. It may intervene to sanction illicit sexual relations. In this case, however, the purpose is to protect persons who are exposed to exploitation, not to intervene in a joint decision to procreate: OLRC, *supra*, note 2 at 106ff.

486. LRC, *Sterilization: Implications for Mentally Retarded and Mentally Ill Persons*, Working Paper 24 (Ottawa: Supply and Services Canada, 1979); Symposium of the Association québécoise pour l'étude comparative du droit, "L'affaire *Eve* et la stérilisation des déficients mentaux" (1987) 18 R.G.D. 641.

of those undergoing such treatment are not scrutinized.[487] If this is the case, why would we wish to treat "artificial" reproduction differently than natural reproduction? Is artificial procreation, too, not a part of the "private ordering approach" insofar as the actual decision to conceive is concerned?[488]

For those opposed to state intervention in medically assisted procreation, society is in the process of coming to terms with all these discoveries and will ultimately consider their use a matter of course, as has been the case with so many other discoveries in the past. However, most defenders of this approach recognize the need to attach certain legal consequences to individual choices and to impose controls over the way at least some of the technologies are applied. These controls will be examined later, but suffice it to say for the time being that, in general, they are designed to ensure the quality of the services provided and, by extension, to protect the "recipients." In any event, defenders of this position do not question the legitimacy of using the various technologies associated with medically assisted procreation.

Individual freedom can also be advocated at this stage simply because any intervention is considered premature, as discussion of the issues is not yet sufficiently advanced to permit standards to be issued. What is therefore needed is community-wide reflection.[489]

A full private ordering approach does not, however, have widespread support. It fails to answer any of the fundamental questions raised by the application to humans of scientific discoveries in the area of procreation, and it does not provide conscientious researchers with the guidelines they are seeking. It also creates difficulties in terms of the administration of justice. For example, the legal status of children born of medically assisted procreation has yet to be resolved, and control of gametes and embryos is foundering in a legal void.

The role of individual control in medically assisted procreation can be increased with proper public awareness and education. The task is to present the issues associated with new technologies to the public as objectively as possible. First to be addressed are the issues that affect individuals: the advantages and disadvantages for those using the technologies, the success and failure rate of each technology in the context in which it is used; and the physical and psychological risks for all of the people concerned. Next are the issues that affect future generations and society as a whole: the longer-term issues for the embryo, the fetus, the unborn child and the future of the human race; the fate of surplus embryos; the possible benefits to researchers — in short, all the major issues

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487. OLRC, *supra*, note 2 at 110.

488. *Ibid.* at 118. Thomas A. Eaton, "Comparative Responses to Surrogate Motherhood" (1986) 65 Neb. L. Rev. 686 at 707.

489. Rubellin-Devichi, *supra*, note 314 at 457-59.

currently being debated in various forums. However, it is difficult to guarantee that public education will be objective because it will always be based on information from many different sources. It could therefore be influenced by the fragmentation of the sources of information and might even be distorted by the unbridled confidence of some researchers and the sensationalism that sometimes characterizes the media.

This approach may also be accompanied by a promotion of values designed to instil a sense of responsibility in all the individuals concerned, and remind them that respect for human dignity must always take precedence over immediate individual interests. The positions taken by moral and religious authorities reflect this trend.[490]

Similar views can be seen in the positions adopted by various ethics bodies, which we will discuss later. Again, these positions must be conveyed to the general public, as the National Advisory Ethics Committee for the Life and Health Sciences in France is endeavouring to do.[491] The recommendations of the American Fertility Society also stress the dissemination of information and moral counsel and the use of persuasion to enable people to make informed choices and gradually to alter public attitudes.[492]

These and other similar measures are vital to a better understanding by the general public of the real issues at stake in medically assisted procreation. But the basic information must from the start be non-denominational and non-political. And it should not be associated with specific groups, such as scientists, health professionals and women, although these groups do have an important role to play. No matter how active they might be in public education, these groups do not always display the objectivity needed to provide neutral information.[493]

One might ask what type of audience is reached by ethics bodies and moral and religious authorities? For Jacqueline Rubellin-Devichi, the opinions they issue have a considerable influence on public opinion.[494] This is probably the case in Europe, but does it also hold true in Canada?

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490. See, in particular, Congregation for the Doctrine of the Faith, *Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation* (Vatican City: Vatican Polyglot Press, 1987); Gérard Mémeteau, "Le Comité National Consultatif d'Éthique et l'enfant conçu" in *La vie prénatale, biologie, morale et droit: Actes du VI^e Colloque national des Juristes Catholiques, Paris, 15-17 novembre 1985* (Paris: TÉQUI, 1986) at 67; Edouard Bone and Jean-François Malherbe, *Engendrés par la science: Enjeux éthiques des manipulations de la procréation* (Paris: Cerf, 1985) at 33, referring to the suggestion in this connection of some Nobel Prize winners regarding "reproduction permits" and "quality tests" of the newborn child.

491. Comité consultatif national d'éthique pour les sciences de la vie et de la santé, *Journées annuelles d'éthique* (Paris: La Documentation française, 1986) at 31.

492. The American Fertility Society, The Ethics Committee, *supra*, note 187 at 21Sff. and 73Sff.

493. For example, some view reproductive technologies as nothing more than exploitation of women's bodies for scientific research and "production" and as a result fail to see their contribution to procreation. This type of attitude was evident during the international forum, *Sortir la maternité du laboratoire* (Quebec: Conseil du statut de la femme, 1988). On the other hand, the attitudes reflected in studies such as the Conseil du statut de la femme, *Nouvelles technologies de la reproduction: pratiques cliniques et expérimentales au Québec* (Quebec: The Council, 1986) and the study by the Alberta Advisory Council on Women's Issues, *Discussion Paper on New Reproductive Technologies: Medical, Legal and Ethical Implications* (Edmonton: The Council, 1988), bear witness to the important contribution of these groups.

494. *Supra*, note 314 at 457.

The position taken by the Catholic Church, which opposes medically assisted procreation outright, raises some reservations.[495] For the United Church, artificial insemination with donor may be a legitimate choice in terms of ethics and morality.[496] Surrogate motherhood itself could be admissible in very special circumstances.[497]

Is education alone enough, given the issues raised by medically assisted procreation? Apparently not: education will raise awareness but has no compelling influence. It therefore offers no protection against the dangers of abuse or against commercialization of the technologies. As Jean-Louis Baudouin and Catherine Labrusse-Riou point out, it is unrealistic to rely on self-discipline.[498] Public education is an important, even essential, step because we are looking for the solution or solutions to what is first and foremost a problem for all of society and not just an individual problem. Public education can discourage the abuse or inappropriate use of the technologies made possible by science, but it is unlikely to have any impact on unscrupulous people.

B. Professional Control

The quality of a medical treatment may be controlled as to both its indication and its performance. Control may go beyond this practical stage and question the moral value of applying scientific discoveries; this is the role of ethics. In this regard, standards may be issued by professional associations or recommended by multidisciplinary committees.

1. The Medical Profession

Procreation assistance technologies are a type of therapeutic treatment and are naturally a part of the medical profession. This is certainly true of the more complex technologies that require special resources and a special environment. Artificial insemination, on the other hand, can easily be performed without special training. However, it is not without risk.

Physicians are required to comply with the standards of good medical practice as defined by their professional associations within limits set by the courts. These standards are designed to protect the public from unqualified individuals[499] — in other words, malpractice or unlawful practice — and to set a benchmark for professional practice that

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495. Congregation for the Doctrine of the Faith, *supra*, note 490 at 5ff.: the Congregation bases its opposition on the separation of sexual relations and procreation, which in its view fails to respect the dignity of the person. It fears the "technologization" of procreation. The Ethics Committee of the American Fertility Society has published a second discussion paper in response to the Instruction from Rome: "Ethical Considerations of the New Reproductive Technologies" (1988) 49:2 (Supp. 1) Fertil. Steril.

496. United Church of Canada, Division of Mission in Canada, "A Brief to the Royal Commission on New Reproductive Technologies," 1991, at 9-10 [unpublished].

497. *Ibid.* at 12.

498. *Supra*, note 210 at 208.

499. *Ibid.*

may be considered by the courts in the event of a dispute.[500] Assuming that professional associations adopt positions on the basic legitimacy of assisted procreation, as some have already done,[501] and set ethical guidelines for the use of new technologies by their members, effective sanctions must be devised for those who violate these guidelines.[502] Standards, where they do exist, have no legal force unless they are included in regulations, as is the case, for example, with the Quebec codes of professional ethics.

In France, the Conseil d'État recommends specific sanctions for professional misconduct and urges professional associations to endeavour to prevent the misuse of new technologies. It even suggests that criminal sanctions be imposed for violating basic rules and procedures and for ignoring the advice of an ethics committee.[503] Even then there is the problem of enforcement, especially when such fundamental choices are involved. Further, there is something of a tradition of secrecy and moral independence surrounding professional associations, and this could raise doubts about their ability to ensure real control that is sufficiently credible to the public. And if control of the application of discoveries were left to professional associations, standards would perhaps vary from one association to another, from one province to another and from one country to another, and it would be impossible to set the standard rules that most of those involved would like to see adopted.

Finally, as the members of the Quebec task force noted, [TRANSLATION] "regulation of human reproduction technologies is a matter of social policy that must not be identified with the development of standards for the professional quality of the services." The task must therefore "not be left to the medical profession or to the other professions that are directly involved."[504]

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500. For example, standards issued by The American Fertility Society influenced the court in *York* v. *Jones Institute*, *supra*, note 204 (transfer of a frozen embryo from one clinic to another). See also P. Widmer, "Les perspectives législatives, en particulier vues du Conseil de l'Europe" in *Artificial Procreation, Genetics and the Law: Lausanne Colloquium of November 29-30, 1985* (Zurich: Schulthess Polygraphischer Verlag, 1986) 211 at 213. For a general discussion of the role of the courts, see "The Courts," *infra* at 110.

501. On all or only some technologies. For example, The American Fertility Society, The Ethics Committee, *supra*, note 187 at 62Sff., favours considerable reproductive freedom but is opposed to surrogate motherhood for convenience and has reservations about the actual process. The Swiss Academy of Medical Sciences in *Directives médico-éthiques pour la procréation médicalement assistée* (Petersplatz: The Academy, 1990) recognizes the validity of in vitro fertilization for medical reasons, provided it is performed in the case of married couples or unmarried couples living a conjugal life (directive 3.1 at 2) and rejects surrogate motherhood (directive 12.6 at 5). The Conseil de l'Ordre des médecins in France accepts procreation assistance within the couple, has reservations about the intervention of unknown donors, and rejects surrogate motherhood and embryo donation: in Comité consultatif national d'éthique pour les sciences de la vie et de la santé, *supra*, note 491 at 33. In Canada, the ethics committees of the Canadian Fertility and Andrology Society and the Society of Obstetricians and Gynaecologists of Canada have published a document listing their recommendations on all medically assisted procreation technologies: see *Ethical Considerations of the New Reproductive Technologies* (Toronto: Ribosome Communications, 1990).

502. Knoppers and Sloss, *supra*, note 269 at 669 n. 3, and the reports quoted therein.

503. Conseil d'État, *Sciences de la vie: De l'éthique au droit*, 2d ed. (Paris: La Documentation française, 1988) at 122-23.

504. Ministère de la Santé et des Services sociaux, *Rapport du Comité de travail sur les nouvelles technologies de reproduction humaine* (Quebec: The Department, 1988) at 152.

Without standards from their professional associations or regulations developed at another level, physicians are faced with a dilemma: in dealing with medically assisted procreation, should they simply meet the demand, or should they instead question the values involved, consider the common good and exercise their own judgment?[505] Leaving health professionals alone to set the ground rules in so complex a field puts a very heavy burden on them.

2. Local Ethics Committees

There are presently two major types of hospital or institutional ethics committees — research ethics committees and clinical ethics committees — and each type has a role to play in medically assisted procreation. Rather than give a complete background, we will simply state briefly that research ethics committees have been mandatory in Canada since 1978 for any research funded by the Medical Research Council of Canada: before a project is submitted to the Council, it must be approved by a local committee in accordance with the Council's general criteria.[506] Multidisciplinary committees are desirable but not mandatory; in some institutions, the committee is made up entirely of scientists. The main objective of research ethics is also to protect subjects in terms of both the inviolability of the person and the right to privacy. The Medical Research Council has issued special guidelines for research on embryos.[507] The guidelines are extremely important because in most centres the use of in vitro fertilization produces surplus embryos. This raises a number of questions about embryos that will not be given to another infertile couple, among them storage, experimentation, destruction and *ex utero* development.

Since research on the treatment of infertility is costly and is for the most part funded by official agencies, ethical controls are generally applied. However, these controls are not always entirely successful: the local approval process is not always as thorough as it should be, and there is much criticism of the lack of project follow-up once initial approval has been obtained. What is more, when the research is carried out by a private company the controls do not apply.[508] In addition, the controls no longer come into play once the technology is past the experimental stage. In effect, most medically assisted procreation technologies can now be used in fertility clinics and would therefore fall under the jurisdiction of *clinical* ethics committees.

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505. Guy Durand, "La bioéthique est une des principales préoccupations de la profession médicale" (1987) 116:6 L'Union médicale du Canada 343 at 350. See also Charles H. Baron, "Fetal Research: The Question in the States" (1985) 15:2 Hast. Cent. Rep. 12 at 15.

506. See Jean-Louis Baudouin, Monique Ouellette and Patrick A. Molinari, *Toward a Canadian Advisory Council on Biomedical Ethics*, Study Paper (Ottawa: Law Reform Commission of Canada, 1990) at 13ff.

507. Medical Research Council of Canada, *Guidelines on Research Involving Human Subjects* (Ottawa: Supply and Services Canada, 1987) at 33-34. Most of the papers, reports and recommendations mentioned in this working paper consider this aspect as well. See also *Biomedical Experimentation Involving Human Subjects*, *supra*, note 7.

508. The standards of the Medical Research Council of Canada can nevertheless be applied by hospital ethics committees when they consider research projects funded by the private sector.

The number of clinical ethics committees around the world has grown astronomically over the past ten years, and much has been written about them.[509] These multidisciplinary bodies are generally able to address the problems referred to them from a much broader perspective. Their role is essentially an advisory one. In 1986, the Canadian Hospital Association recommended the creation of ethics committees in all major hospitals.[510]

Clinical ethics committees are usually consulted when the attending physician feels he or she has a difficult decision to make or when there is a disagreement with the family or the medical team. But unless the institution has internal regulations requiring consultation in specific cases, the attending physician is free to treat patients for infertility as he or she sees fit; in other words, the physician can decide according to his or her own professional judgment to use medically assisted procreation technologies as soon as they are past the experimental stage. It should therefore come as no surprise that the criteria for using the technologies vary considerably.

In France, the centres for the study and storage of human sperm, or CÉCOS, have endeavoured to draft a common ethics policy. [TRANSLATION] "It became clear that the problems encountered were more than merely technical and demanded consideration of the very nature of artificial procreation through gamete donation, the significance of and rationale for the procedure, the inherent risks and the limits to be imposed."[511] However, this policy applies only to frozen sperm, not fresh sperm, which physicians remain free to use as they wish.[512] These regulations can also be circumvented by consulting private gynecologists.[513] Opinion is also divided on the issue of compensation. The Quebec departmental task force[514] points out that each clinic has its own rules.

Local committees still have undeniable advantages: apart from playing a role in education, as discussed above, they have very flexible operating structures and, with the proper membership, can be used to take the pulse of society.[515] The ethical rules that emerge can in the medium term provide inspiration for lawmakers. However, as has been noted,[516] they are but a temporary substitute for legislative intervention because they are not of any real effect unless they are accepted by patients. In disputes, they cannot be used as a basis for a court ruling unless they have somehow been incorporated in a statute or in regulations.[517]

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509. Baudouin, Ouellette and Molinari, *supra*, note 506 at 7.

510. Durand, *supra*, note 505 at 353; and Baudouin, Ouellette and Molinari, *supra*, note 506 at 7.

511. P. Jalbert and G. David, "Problèmes génétiques liés à la procréation artificielle par don de gamètes: solutions adoptées par les CECOS" (1987) 16 J. Gynecol. Obstetr. Biol. Reprod. 547 at 548.

512. Rubellin-Devichi, *supra*, note 314 at 460; Alain Sériaux, "Droit naturel et procréation artificielle : quelle jurisprudence?" *D.* 1985, 53 at 54, no. 4.

513. Jacqueline Rubellin-Devichi, "Le droit, les pères et la parernité" (1988) 24:3 Rev. Droit sanit. et soc. 425 at 435.

514. Ministère de la Santé et des Services sociaux, *supra*, note 504 at 107ff.

515. This is even more true of national committees: LeRoy Walters, "Ethics and New Reproductive Technologies: An International Review of Committee Statements" (1987) 17:3 (Supp.) Hast. Cent. Rep. 3.

516. Dominique Thouvenin, "Éthique et droit en matière biomédicale" *D.* 1985, 21 at 24-25, nos 12-13.

517. *Ibid.* at 23, no. 7.

Codes of ethics typically impose nothing more than minimum standards, and in dealing with patients, physicians must take into account their interests and their wishes. Ethical rules alone are not sufficient to deal with the problems raised by medically assisted procreation technologies.[518]

C. Community Control

1. Permanent Provincial or National Ethics Committees

Reference was made above to the regulations currently in place governing research. The need to regulate experimentation became apparent at the end of World War II, when it was discovered that horrifying experiments had been conducted without regard for the human subjects of them, on the grounds that the pursuit of knowledge justified whatever means might be used. Research ethics committees are in a position to impose rules because of their role in determining funding. Before issuing regulations, they normally consult broadly with the parties directly involved and with the general public. Their activities do not seem to give rise to opposition.[519]

When it comes to dealing not with research, that is, the acquisition of new knowledge, but rather with the application of that knowledge, ethical issues take on a very strong social dimension. For this reason, a number of authors and reports propose the creation of a national ethics committee where one does not already exist.[520] The American Fertility Society has also emphasized the need for national consultation. Gorovitz writes that "we need an independent agency of reflection and recommendation that is respectful of the full range of sentiment on such matters, and at the same time has the freedom and courage to take the stands that seem most justified — in full awareness that any stand on these matters will draw opprobrium from some quarters."[521]

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518. Knoppers and Sloss, *supra*, note 269 at 671 n. 7 and the reports mentioned therein.

519. For an overview of the main committees, see Durand, *supra*, note 505 at 352; Robertson, *supra*, note 483 at 19. See also *Biomedical Experimentation Involving Human Subjects*, *supra*, note 7; and Baudouin, Ouellette and Molinari, *supra*, note 506.

520. Specifically, Council of Europe, P.A., 38th Sess., Pt II, *Texts Adopted, Recommendation 1046 (1986) on the Use of Human Embryos and Foetuses for Diagnostic, Scientific, Industrial and Commercial Purposes*, s. 14 vii [hereinafter *Recommendation 1046 (1986)*]; Warnock Report, *supra*, note 421; The Committee to Consider the Social, Ethical and Legal Issues Arising from In Vitro Fertilization, *Report on the Disposition of Embryos Produced by In Vitro Fertilization* (Melbourne: F.D. Atkinson Government Printer, 1984) (Chair: Louis Waller) [hereinafter Waller Report]; Federal Ministry of Justice, Federal Ministry of Research and Technology, *Report: Working Group on In Vitro Fertilisation, Genom Analysis and Gene Therapy* (Federal Republic of Germany: J. Schweitzer Verlag, 1985) (Chair: Ernst Benda) [hereinafter Benda Report]; Knoppers and Sloss, *supra*, note 269 at 670; Jacqueline A. Priest, "The Report of the Warnock Committee on Human Fertilisation and Embryology" (1985) 48 Mod. L. Rev. 73 at 74; Samuel Gorovitz, "Engineering Human Reproduction: A Challenge to Public Policy" (1985) 10 J. Med. Phil. 267 at 271. See also Baudouin, Ouellette and Molinari, *supra*, note 506.

521. Gorovitz, *supra*, note 520.

Without compelling authority, how can ethical choices be imposed on those with different views? More to the point, what can be done to prevent commercialization, the proponents of which do not see beyond the law of supply and demand? The protracted search for an unattainable consensus is allowing new technologies to develop uncontrolled. It reflects [TRANSLATION] "the disarray of a society which, lacking a clear direction, intends to rely on a committee of scholars. . . . Is it possible that the future will be one of ethical rather than political laws?"[522] And are we to see in this an abdication of public authority?

2. The Courts

In the absence of clear legislation, the courts are among the first public institutions we turn to for settling disputes. Reference to the courts brings fundamental issues to the attention of the public and sparks the debate that is needed for any form of action, including legislative action.[523] The publicity afforded such issues by the media enables the courts to play a role in increasing public awareness. "Public policy may be affected by litigation and media attention. This in turn may affect the legislative approach that is chosen."[524]

Existing laws do not deal specifically with medically assisted procreation.[525] Some, however, include provisions that may serve to govern a number of new situations. [TRANSLATION] "The concept of the interest of the child, an elastic concept open to a wide range of interpretations, has until now been used as the basis for decisions in cases involving new reproductive technologies and especially surrogate motherhood."[526]

However, the application of existing rules to deal with a situation not anticipated when such rules were developed, such as recourse to the principles of natural justice, is not without problems.

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522. Thouvenin, *supra*, note 516 at 26, no. 15.

523. Take, *e.g.*, the *Quinlan* case (70 N.J. 10 (1976)) referred to in Baudouin, Ouellette and Molinari, *supra*, note 506 at 7. See also the comments by the Supreme Court of New Jersey in *Baby M*, *supra*, note 302 at 1264.

524. Veronica L. Payne, "The Regulation of Surrogate Motherhood" (1987) 17 Fam. L. 178.

525. See *supra*, note 479.

526. Michèle Rivet, "Le rôle du juge et des parlements en matière de procréation assistée" (1990) 1:1 International Journal of Bioethics 49 at 52:

> [TRANSLATION]
> In the whole area of parentage, the shift that has come about from a 'social' truth to be protected to a 'biological' truth to be recognized has given greater place to some aspects of 'fictitious' or consensual truth. Now the trend is toward a 'psychological' truth that springs from the very notion of the interest of the child, as a person with legal existence. Our courts will no doubt still have to rule on claims of parentage and custody disputes between surrogate mothers who want to keep their children and biological fathers who claim the offspring, and they may then use this concept of the interest of the child.

See also *supra*, chap. 2.

For some of the issues raised by medically assisted procreation, the legislation now in place is of little use to the courts. This may lead the courts to avoid ruling on the fundamental questions underlying the disputes brought before them. This is what occurred, for example, in the *Parpalaix* case in France, where the judgment dealt only with the return of frozen sperm to the widow, while the real social and ethical issue was post mortem insemination.[527] Further, while the discretion granted to judges may prove beneficial to some parties in a dispute, it also creates tremendous disparity in court rulings. The result for those who are parties to court actions is uncertainty as to the outcome of the case.

The judicial route therefore has its limits and does not offer a comprehensive solution to the problems associated with medically assisted procreation.

D. Legislative and Regulatory Control

1. Legislative Control

To the extent that courts, ethics committees, professional associations and citizens' sense of personal responsibility are inadequate to ensure the desired control over all medically assisted procreation technologies or specific aspects of those technologies, legislative intervention, with all the necessary reservations and qualifications it implies, may be needed. It may be also needed to fill the gaps in positive law regarding some of the consequences of medically assisted procreation, including the parentage of children and control over gametes and embryos, in order to uniformize the situation in a given province or state, within a country or even internationally.[528] This approach may also be useful in examining the values of our society at a given point in history. There is not a single report or national committee that does not recommend some form of legislative intervention.[529]

Public education may make the general population more aware of the issues and make freedom of choice more informed. Professional control and ethical review will limit the risk of abuse in the application of the technologies involved. The courts, by definition, deal only with disputes brought before them, which represent only a small proportion of the number of cases of medically assisted procreation, even surrogacy.[530]

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527. *Supra*, note 202. See Jones, *supra*, note 147.

528. D.G. Dickman, "Social Values in a Brave New World: Toward a Public Policy Regarding Embryo Status and In Vitro Fertilization" (1985) 29 St. Louis U. L.J. 817; Robertson (1986), *supra*, note 381 at 952 n. 48; Gorovitz, *supra*, note 520 at 269 and 271; Sériaux, *supra*, note 512 at 54, no. 4; Knoppers and Sloss, *supra*, note 269 at 667ff.; Baudouin and Labrusse-Riou, *supra*, note 210 at 252.

529. See, *inter alia*, Warnock Report, *supra*, note 421; Benda Report, *supra*, note 520; Waller Report, *supra*, note 520; OLRC, *supra*, note 2; Ministère de la Santé et des Services sociaux, *supra*, note 504; Barreau du Québec, *supra*, note 3; and Conseil d'État, *supra*, note 503.

530. See in particular the studies on surrogacy in Canada: Margrit Eichler and Phebe Poole, "The Incidence of Preconception Contracts for the Production of Children among Canadians," Study prepared for the LRC, September 1988 [unpublished]; Ministère de la Santé et des Services sociaux, *supra*, note 504; Conseil du statut de la femme, *supra*, note 493; Alberta Advisory Council on Women's Issues, *supra*, note 493.

Social regulation and the emergence of non-statutory standards[531] have an undeniable impact. They bear witness to an interest and a sense of responsibility present in a growing number of individuals. But it must be remembered that legislative intervention, a last-resort means of control and sanction, is bound to create some stumbling blocks.

Some writers suggest that positive state law is not the way to control all these issues.[532] A law that is enacted and subsequently proves to be unenforceable risks being ignored, thereby missing its target altogether.[533] There are also fears that, despite appearances, legislation would not necessarily give everyone adequate protection.[534] Others point to the risk of passing legislation hastily under pressure from the courts, public opinion and the media[535] when there is still no consensus.[536]

Of course, it is important not to make a decision too swiftly. We must take the time to weight the pros and cons of legislative intervention, consider public opinion, define the ethical bases on which to act[537] and take pains to avoid dogmatism.

2. Regulation of Procedures

Legislative intervention may be sweeping or compartmentalized or may simply consist in regulatory control of practices. The proliferation of public and private centres in which medically assisted procreation technologies are applied obviously makes the task of applying controls more difficult, whether the controls are aimed at application standards, the quality of professional services or the cost of health care. Many reports therefore suggest that licences be issued to institutions and/or professionals providing procreation assistance services.[538] In England, according to the Warnock Committee, the licensing authority should have the power to set standards for professional practice and research on medically assisted procreation and advise the government on specific matters.[539] This same general

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531. Michèle Rivet, "Les nouvelles technologies de reproduction: les limites de la loi" in Gérald A. Beaudoin, ed., *Vues canadiennes et européennes des droits et libertés: Actes des Journées Strasbourgeoises 1988* (Cowansville, Que.: Yvon Blais, 1989) 443 at 449ff. See Rocher, *supra*, note 480; Jean-Guy Belley, "L'État et la régulation juridique des sociétés globales" (1986) 18 Sociologie et sociétés 11.

532. Rubellin-Devichi, *supra*, note 314 at 457-59 and n. 7; Gorovitz, *supra*, note 520 at 271.

533. Rubellin-Devichi, *supra*, note 314 at 457-59; Gorovitz, *supra*, note 520 at 271; Council for Science and Society, *Human Procreation: Ethical Aspects of the New Techniques* (Oxford: Oxford University Press, 1984) at 84, no. 8.6; Kidder, *supra*, note 9.

534. Hutton Brown *et al.*, "Legal Rights and Issues Surrounding Conception, Pregnancy, and Birth" (1986) 39 Vand. L. Rev. 597 at 665.

535. Payne, *supra*, note 524 at 178.

536. OLRC, *supra*, note 2 at 124; Payne, *supra*, note 524 at 180; Rubellin-Devichi, *supra*, note 314 at 496; Ministère de la Santé et des Services sociaux, *supra*, note 504 at 140; Council for Science and Society, *supra*, note 533 at 84, no. 8.5. For a general discussion of the subject see Kidder, *supra*, note 9.

537. Payne, *supra*, note 524.

538. See *infra*, appendix A at 173.

539. Warnock Report, *supra*, note 421 at 75ff. The Benda Report, however, *supra*, note 520, holds the view that such standards should be set out in legislation.

approach has been adopted by some states in Australia.[540] In this context, professional associations are without question very much involved in setting standards in the public interest. For the Quebec task force, the responsible agency would be the Department of Health and Social Services, which would set up an evaluation team to visit institutions periodically.[541] France's Conseil d'État recommends a certification system in accordance with the law and subject to administrative sanctions (revocation of licence) or criminal sanctions (for directors) in the event of a violation, as well as civil liability.[542]

This type of regulation, which is inevitable if social service agencies are to take charge of infertility treatment, also makes it possible to guarantee uniform standards for all centres and therefore greater fairness to the public and more transparent practices.[543] It would not prevent local ethics committees from ruling on specific cases. This approach would also permit better management of all the data related to artificial procreation. The Council of Europe recommends the establishment of a registry of all duly certified and authorized centres.[544] The Ontario Law Reform Commission notes that the remoteness of centres may have an impact on accessibility; the Commission adds that this phenomenon is not unique to infertility treatment but holds for all types of fairly specialized health care.

II. The Role of the State and the Federal Government in the Reform Process

A. The Role of the State

Any legislative or state intervention in medically assisted procreation should be aimed at promoting values that society holds fundamental,[545] such as the right to privacy and procreative autonomy,[546] respect for the physical and mental integrity of patients,[547]

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540. See *infra*, appendix A at 198ff. Compare OLRC, *supra*, note 2 at 129 and 275ff.

541. Ministère de la Santé et des Services sociaux, *supra*, note 504 at 152.

542. Conseil d'État, *supra*, note 503 at 63-64, ss 9-12. The use of medically assisted procreation as provided for in the law must be under the supervision of the social security ministry: *ibid.* at 67, s. 53.

543. See Ministère de la Santé et des Services sociaux, *supra*, note 504 at 152; Comité consultatif national d'éthique pour les sciences de la vie et de la santé, *supra*, note 491 at 30.

544. *Recommendation 1046 (1986)*, *supra*, note 520, s. 14 vi.

545. For France, see Catherine Labrusse-Riou, "Servitude, servitudes" in Bernard Edelman and Marie-Angèle Hermitte, eds, *L'Homme, la nature et le droit* (Paris: Christian Bourgois, 1988) 308 at 326, where she writes that [TRANSLATION] "if we wish to humanize life, then the role of public policy is, on the one hand, to recognize the human being as different from objects or from other living forms and, on the other, to protect the integrity, the dignity and the nature of individuals as subjects."

546. See *R.* v. *Jones*, *supra*, note 336 at 318-19 and *Sterilization: Implications for Mentally Retarded and Mentally Ill Persons*, *supra*, note 486 at 63 (procreative liberty); *Crimes against the Foetus*, *supra*, note 7 at 39.

547. *R.* v. *Morgentaler*, *supra*, note 336 at 60-63.

equality,[548] the protection of life,[549] special protection of children and those who are otherwise unable to protect themselves or who are vulnerable to harm or exploitation by reason of incapacity.[550] Indeed, Canadian society tends to regard many of these values as fundamental rights that give legal content to the moral concept of human dignity.[551]

Such values and rights help define the various roles the state may play in medically assisted procreation. On the one hand, the rights to privacy, confidentiality and autonomy do not admit of burdensome or unwelcome governmental intrusion into reproductive choices. This view inspired former Prime Minister Trudeau's famous comment — "[t]he state has no place in the nation's bedrooms" — when, over two decades ago, the promotion of contraceptives, among other things, was decriminalized.[552] It also inspires impassioned arguments against state control of assisted procreation technologies and against state power to decide who may procreate.[553]

On the other hand, a societal commitment to children's interests and rights,[554] and to protecting those who cannot protect themselves, would seem to call for an active and supportive government role in advancing reproductive health and family life. This view helps legitimate laws that grant children born using medically assisted procreation access to confidential records for medical or genetic information essential to their health.

Between the polar extremes of the state as oppressor and the state as protector-liberator lies a spectrum of supportive roles the state may assume in fulfilling its democratic mandate respecting medically assisted procreation: namely, as dispute arbiter, health service provider, public financier, lawmaker, researcher, protector of public health, safety and

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548. See *Canadian Human Rights Act*, *supra*, note 454, s. 3, prohibiting discrimination, *inter alia*, on grounds of family or marital status, gender, disability; and s. 15 of the *Canadian Charter of Rights and Freedoms*, *supra*, note 10. For a consideration of federal government obligations under international law in preventing discrimination and promoting equality by virtue of its international treaty obligations, see *International Covenant on Civil and Political Rights*, 16 December 1966, Can. T.S. 1976 No. 47, 999 U.N.T.S. 171, s. 26.

549. See *R.* v. *Wetmore*, [1983] 2 S.C.R. 284 at 288-89; and *Labatt* v. *Attorney General of Canada*, [1980] 1 S.C.R. 914 at 932-34: the traditional ends of criminal law include protecting public security, health, morals; the Court discusses *Russell* v. *The Queen* (1882), 7 App. Cas. 829 (P.C.) and *Reference re Validity of Section 5(a) of the Dairy Industry Act*, [1949] S.C.R. 1. See also *R.* v. *Crown Zellerbach Canada Ltd.*, [1988] 1 S.C.R. 401 at 442, 447, concerning contrasting national health protection initiatives under the criminal law power and under the peace, order, and good government power.

550. See *E. (Mrs.)* v. *Eve*, *supra*, note 385.

551. See *Morgentaler*, *supra*, note 336 at 164-66.

552. John Robert Colombo, ed., *New Canadian Quotations* (Edmonton: Hurtig, 1987) at 311. See also S.C. 1968-69, c. 41, s. 13 (amending former s. 159(2)(*c*) — now s. 163(2)(*c*) — of the *Criminal Code*). The amending law, also incorporated into the federal *Food and Drugs Act*, *supra*, note 298, contains express provisions for the regulation of contraceptive devices.

553. Compare *Sterilization: Implications for Mentally Retarded and Mentally Ill Persons*, *supra*, note 486; *Eve*, *supra*, note 385; *Skinner* v. *Oklahoma*, *supra*, note 369; and Aldous Huxley, *Brave New World* (London: Chatto & Windus, 1932).

554. See Martha Minow, "Rights for the Next Generation: A Feminist Approach to Children's Rights" (1986) 9 Harv. Women's L.J. 1 at 18. See also Landau, ed., *supra*, note 279.

human life, strong and benevolent defender and promoter of human rights, or mere administrator of birth records.[555] The precise roles are determined partly by historical and still evolving state roles in reproductive health, and partly by fundamental and evolving values that define and structure legal relations between the individual, the family and the state.[556]

Many of the values underlying these various state roles are given expression by local, regional and national governments. Thus, provincial and territorial governments may license and regulate fertility and sterility specialists and clinics, as they do midwives, obstetricians and hospitals. They might help provide and pay for artificial insemination and IVF services for their residents, as they do for surgical treatment of infertility. They might prohibit discrimination in the delivery of fertility services, as they do for adoption or hospital services.[557]

B. The Role of the Federal Government

The federal government derives its national health role and public responsibilities from the same value base. The value of protecting life, expressed constitutionally in the duty to protect Canadian public health and safety under the criminal law power,[558] underlies the federal responsibility for certifying the safety and efficacy of therapeutic agents that affect fertility and sterility. Thus, the federal government regulates prosthetic tubes used in reconstructive surgery of the fallopian tubes, as it does fertility drugs and condoms — the latter of which help prevent the spread of sexually transmitted diseases that cause sterility.[559] Such jurisdiction over safety issues — complemented by federal jurisdiction over interprovincial and international commerce — extends to regulating the import and export of reproductive tissues, drugs, and medical devices.[560]

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555. See Jones, *supra*, note 147 at 540 n. 75.

556. See Michael D.A. Freeman, *The State, the Law and the Family* (London: Sweet & Maxwell, 1984); and "Symposium: The Family, the State and the Law" (1985) 18:4 U. Mich. J.L. Ref.

557. See, *e.g.*, the Ontario *Human Rights Code, 1981*, *supra*, note 454, s. 1, which applies to services and facilities; *Peters* v. *University Hospital Board*, [1983] 5 W.W.R. 193 (Sask. C.A.).

558. Compare *Wetmore*, *supra*, note 549 at 288, 293 (federal *Food and Drugs Act* protection of national public safety and health based on the criminal law power) and *Quarantine Act*, R.S.C. 1985, c. Q-1, based on s. 91(11) and (27) of the *Constitution Act, 1867* (U.K.), 30 & 31 Vict., c. 3. For further discussion of the criminal law power, see François Chevrette and Herbert Marx, *Droit Constitutionnel* (Montreal: P.U.M., 1982) at 742-45; and Peter Hogg, *Constitutional Law of Canada*, 2d ed. (Toronto: Carswell, 1985) at 399-402.

559. See *Food and Drugs Act*, *supra*, note 298; federal licensing of the fertility drug clomiphene citrate was granted some 25 years ago (see *supra*, note 33).

560. For a discussion of federal import-export and quarantine duties under the *Food and Drugs Act*, *supra*, note 298, see *Procurement and Transfer of Human Tissues and Organs*, *supra*, note 250. In this regard, Agriculture Canada has for years administered a national health protection regime to govern the thousands of animal embryos and millions of semen doses that cross the border annually. See the *Animal Disease and Protection Regulations*, C.R.C. 1978, c. 296, ss 32, 50, 59, 84 and 115, adopted under the *Animal Disease and Protection Act*, R.S.C. 1985, c. A-11, recently replaced by the *Health of Animals Act*, S.C. 1990, c. 21, ss 2, 14, 16 and 19. These initiatives would seem to flow from the federal criminal law, quarantine, trade and commerce, and agricultural powers.

Similarly, the federal government promotes the values of liberty, autonomy and fairness by prohibiting unfair and misleading advertising of medical products and services.[561] This role has been demonstrated by recent U.S. government prosecutions for illegal, false advertising of IVF success rates.[562] Consistent with principles of informed decision making, such laws may help ensure that the Canadian consumer is not harmed, defrauded, or deceived in the purchase of infertility or sterility products and services. Moreover, the funding of infertility research by Health and Welfare Canada, the provision of infertility treatment to members of the Canadian Forces,[563] and the legal entitlement of employees to paid pregnancy and adoption leave[564] — rights predicated on the view that society should no longer place women in the position of having to choose prejudicially between family life and employment opportunities — all illustrate complementary avenues through which the federal government may actively promote reproductive health. Indeed, its obligations with respect to (a) protecting public health, safety, and human life-forms through its criminal law power, (b) regulating international and interprovincial trade through its trade and commerce and quarantine powers, (c) protecting and promoting the national interest by responding to pressing "national concerns," (d) protecting human rights through its *Charter* and human rights obligations, and (e) funding medical research and health services through its spending power — endow the federal government in the modern Canadian state with significant and diverse constitutional and legal bases for protecting reproductive health.[565]

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561. See *Food and Drugs Act*, *supra*, note 298, s. 3; and *R.* v. *Gregory* (1973), 11 C.P.R. (2d) 32 (C.S.P. Que.) (unsubstantiated, misleading health claims prosecuted under *Combines Investigation Act*, R.S.C. 1970, c. C-23). For recent commentary on the evolution of the criminal law and national trade and commerce bases of federal fair competition legislation, see Katherine E. Swinton, *The Supreme Court and Canadian Federalism* (Toronto: Carswell, 1990) at 141-46 and 296-300; Neil Finkelstein, "Constitutional Law — Division of Powers — Constitution Act, 1867, Section 91(2) — Validity of Section 31.1, Combines Investigation Act: *General Motors of Canada Limited* v. *City National Leasing*; *Quebec Ready Mix Inc.* v. *Rocois Construction Inc.*" (1989) 68 Can. Bar Rev. 802.

562. See Proposed Consent Agreement with Analysis to Aid Public Comment, 55 Fed. Reg. 37961-62 (1990); *Federal Trade Commission* v. *Jacobson* (18 May 1989), Virginia 89-0078-A (U.S. Dist. Ct) (enjoining IVF clinic from falsely representing likelihood of pregnancy).

563. Members of the Canadian Forces may receive, at the National Defence Medical Centre or affiliated hospitals, such fertility services as artificial insemination by husband/partner, fertility drugs, reversals of tubal ligations, reversals of vasectomies. Personal communication, Department of National Defence Canada, Office of the Surgeon General, 1990.

564. See *Unemployment Insurance Act*, R.S.C. 1985, c. U-1, ss 18, 20, as. am. S.C. 1990, c. 40, ss 12-14, (17 weeks benefits for pregnancy and adoption leave), discussed in *Brooks* v. *Canada Safeway Ltd.*, [1989] 1 S.C.R. 1219. See also *Canada Labour Code*, R.S.C. 1985, c. L-2, s. 206, 17 weeks statutory pregnancy leave; and *Schachter* v. *Canada*, [1988] 3 F.C. 515 (seeking equivalent paternity leave); aff'd [1990] 2 F.C. 129 (C.A.), leave to appeal to Supreme Court of Canada granted; judgment pending.

565. On these constitutional bases, the federal government has already structured a number of relevant national safety, health protection, health services, and medical financing schemes through the *Food and Drugs Act* (*supra*, note 298), *Quarantine Act* (*supra*, note 558), *Canada Health Act* (R.S.C. 1985, c. C-6), *Department of National Health and Welfare Act* (R.S.C. 1985, c. N-10), *Combines Investigation Act* (R.S.C. 1985, c. C-34 (now the *Competition Act*)) and the *Medical Research Council Act* (R.S.C. 1985, c. M-4). See *supra*, notes 558-561 and *infra*, note 574. See also Andrée Lajoie, Patrick A. Molinari and Jean-Marie Auby, *Traité de Droit de la santé et des services sociaux* (Montreal: P.U.M., 1981) at 891-92.

Finally, the state may also play a critical — and perhaps the quintessentially democratic — role in fostering societal inquiry, debate, study, education and reflection on medically assisted procreation through public forums in which the whole range of viewpoints may be expressed.[566] The recently created Royal Commission on New Reproductive Technologies has been given the mandate to assist government authorities in fulfilling this role through its public hearings in some 20 locales in Canada.[567] Such public debate may influence private reproductive choices in that it makes possible a better understanding of the current implications and provides guidance for future applications of medically assisted procreation.

Indeed, these public processes and forums seem likely to serve as the foundation and catalyst for national consensus, standards and reform. The public pronouncements of prior Canadian royal commissions and the legal initiatives to which they gave rise, as well as more recent public pronouncements from similar bodies in Australia, France, and Denmark are evidence of this.[568] Compelling "national concerns" for which the federal government bears particular responsibilities[569] continue to grow in Canada over such issues as the necessity of guaranteeing minimal but rigorous screening of gamete donors to protect potential recipients' offspring and the public from transmissible diseases; the absence of minimal national requirements for the collection, processing, storage and interprovincial or international distribution of gametes;[570] the moral and legal status of frozen embryos;[571] the legal relation between anonymous gamete donors and resulting offspring;

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566. See Jones, *supra*, note 147 at 545.

567. See P.C. 1989-2150.

568. See *infra*, appendix A at 173, and P.C. Order-in-Council 1976-781 creating the Canadian Advisory Council on the Status of Women, following a recommendation of the *Report of the Royal Commission on the Status of Women in Canada* (Ottawa: Information Canada, 1970) at 389-92.

569. Some aspects of medically assisted procreation issues that have attained national dimensions may require uniform, national legislative solution(s), as demonstrated by an inability of some provinces to address issues in such a way as to avoid "grave consequences" to residents of other provinces. In considering whether a problem is of "national concern" and warrants redress under the federal government's "peace, order and good government" power, courts and lawmakers must ask whether the "national concern" presents the country with a single, distinct or somehow indivisible issue or problem that requires one national law. One test is whether provincial co-operation may realistically solve the problem, given the consequences that may flow from the failure of one province to co-operate. If the analysis reveals the need for one national law, federal intervention must still be reconcilable with the powers and responsibilities of the provinces. See *Crown Zellerbach Canada Ltd.*, *supra*, note 549 at 431-36; Swinton, *supra*, note 561 at 203-08; Hogg, *supra*, note 558 at 375; and Patrice Garant, "La théorie des dimensions nationales: la recherche et l'expérimentation bio-médicales," Paper prepared for the LRC, January 1990 [unpublished]. The doctrine has served as a basis for the federal creation of the national capital region in Ottawa and for federal regulation of radio, aeronautics, marine pollution, and narcotics. See *Crown Zellerbach Canada Ltd.*, *supra*, note 549 at 424-29, 452.

570. Such standards have been called for in Canada for 15 years. See British Columbia Royal Commission on Family and Children's Law, *supra*, note 470; and *Report on Human Sperm 1981*, *supra*, note 148.

571. Assuming that frozen surplus embryos should never be treated "as mere objects," what specific interests, rights or duties define their legal status in different contexts like death or divorce of the donors, or similar situations? See *Biomedical Experimentation Involving Human Subjects*, *supra*, note 7 at 49; *Divorce Act, 1985*, *supra*, note 329, ss 2, 16; *In re Estates of Elsa and Mario Rios*, *supra*, note 204 (no inheritance rights for frozen embryos). See generally "Control over Gametes and Embryos," *supra* at 39.

the potential exploitation of children and women in surrogate motherhood arrangements; and the misleading but avoidable variations in the reporting of IVF success rates.[572] Whether it be because such issues may imperil health, safety and life, or contravene fundamental values and rights, or challenge competing visions of the modern family, they combine to make legal and public policy reforms inevitable in Canadian society.

If legal reforms are to remedy inadequacies in the law, they may begin to do so by minimizing current ambiguities. This may be achieved by better defining the rights, duties, and interests of those affected by medically assisted procreation and the protection they should be afforded. Of course, reasonable minds may differ over whether a particular allocation of rights and duties is fair. But a just allocation of rights, duties and interests should be the common goal in a democratic society. Reformers should also be guided by an active, creative consciousness of the role the law may play in responding to the human need for both freedom and dependency in the various relations between child, adult, family, community and state: "The goal for the future is to devise reforms that help people help themselves — reforms that acknowledge the public as well as private influences on and preconditions for human relationships."[573]

To instil these principles into the legislative reforms that must be carried out in the area of medically assisted procreation in Canada will require a concerted, sustained, imaginative effort by federal, provincial and territorial governments. The articulation of public policy and national medical and bioethical standards will, of course, also depend heavily on the private sector and various communities. How should the process go forward?

The Royal Commission on New Reproductive Technologies is a welcome beginning. Still, in many respects the melding of efforts and views may well require the kind of common vision that underlay the enactment of universal health insurance in Canada years ago. If the enactment of such laws fundamentally and positively altered the relationship between the individual, the hospital and the state in Canadian society, it was because there was a shared vision of individual well-being, social justice and a national "co-operative partnership."[574] Whether changes of that magnitude are in order remains to be seen.[575] Still, similarly co-operative federal-provincial initiatives have led to the Canadian Blood Committee's management of national blood policy, the recently created Canadian Coordinating Office of Health Technology Assessment,[576] and the role of national expert

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572. See *supra* at 13ff.

573. See Minow, *supra*, note 554 at 23.

574. See the preamble to the *Canada Health Act*, *supra*, note 565.

575. Much would seem to depend on societal consensus, even in the important and sensitive domain of national public policy, respecting the necessity, form, and content of laws and policies that express basis principles of justice in the area of procreation.

576. In this sense, the provision of medically assisted procreation services across Canada might be modeled, in part, on the provision of blood transfusion services. Canadians entering hospitals who are in need of blood may currently rely on three levels of federal-provincial co-operation. First, the hospital or clinic that a patient enters is likely to be licensed and regulated under provincial health facilities legislation. Second, to ensure the safety of the nation's blood supply, such clinics, hospitals, and blood banks across Canada must also comply with minimal federal standards on the collection, screening, processing, storage, shipping, and labeling of blood products. Third, the overall management and development of national blood policies and principles are overseen by the national Canadian Blood Committee. See *Procurement and Transfer of Human Tissues and Organs*, *supra*, note 250.

committees in developing Canadian environmental regulations.[577] Such co-operation has been recommended by the Ontario Law Reform Commission.[578] Perhaps a similar vision and similar partnership today would best enable law and policy makers to fashion as able and as just a response to the challenges of medically assisted procreation.

577. See *Canadian Environmental Protection Act*, S.C. 1988, c. 22, s. 6: "For the purpose of establishing a framework for national action and taking cooperative action in matters affecting the environment and for the purpose of avoiding conflict between, and duplication in, federal and provincial regulatory activity, the Minister shall, in cooperation with the governments of the provinces, establish a federal-provincial advisory committee to advise the Minister on (*a*) regulations proposed." See also *ibid.*, s. 34; and Environment Canada, *Canadian Environmental Protection Act: Report for the Period Ending March 1990* (Ottawa: Supply and Services Canada, 1990) at 11.

578. See OLRC, *supra*, note 2 at 275, 277, recs 2, 17.

CHAPTER FOUR

Recommendations

We have already concluded that leaving the application of medically assisted procreation technologies to individual initiative entails too many risks and that the alternatives cannot ensure adequate control of the various aspects of assisted procreation.[579] We must therefore consider the appropriateness of legislative intervention.

Ensuring respect for the fundamental values of society,[580] protecting the public against risks that they cannot protect themselves against, and drafting statutes and principles of law that are capable of resolving potential disputes are, in our opinion, the main considerations that should inform legislative intervention.

The Commission is aware that provincial law has a very important role to play in medically assisted procreation. However, we feel it is essential to deal with the issue on a national scale and to take a comprehensive approach. The recommendations we present in this chapter reflect this view. Since medically assisted procreation raises issues of principle and practice that are of national interest, consistency in the policies adopted is very important. We will also have to consider the appropriateness of and need for a central agency to implement and ensure compliance with these policies throughout the country.

Before dealing with specific issues, we should point out that there are fundamental objections to the use of any or all medically assisted procreation technologies. Some hold that the technologies dehumanize procreation, go against nature and pose a threat to maternity and paternity, which, in this view, cannot be separated from the procreative aspect of sexuality.[581] Further, the use of third-party donations raises concerns about the

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579. See chap. 3.

580. *Crimes against the Foetus*, *supra*, note 7 at 32. *Ibid.* at 31:

> As observed earlier, such principles cannot be found simply by reliance on market research or religious doctrine. In our view, they can only be discovered by reference to our fundamental social values. Such values, we contended in *Our Criminal Law*, are of two kinds. Some are essential to the very existence of society, some to the existence of our own particular society in its present shape and form.

Included in the first category of values are respect for life and the inviolability of the person; included in the second are justice, equality, dignity and individual freedom. See LRC, *Our Criminal Law*, Report 3 (Ottawa: Supply and Services Canada, 1976) at 20-21.

581. See Pope Pius XII, *Discourse to Those Taking Part in the 26th Congress of the Italian Society of Urology*, 8 October 1953: AAS 45(1953) 678; and, more recently, Congregation for the Doctrine of the Faith, *supra*, note 490.

adverse psychological impact on the child and the infertile partner that may result from involving a third person in the make-up of a family unit.[582] As noted earlier,[583] the legitimacy of gamete donation also raises a number of questions. Does it not constitute a [TRANSLATION] "shift in the order of family relationships"?[584] Finally, there are those who maintain that the human embryo must be treated with the same respect and afforded the same protection as the person. They believe it should be forbidden to freeze, destroy[585] or experiment on embryos. Does this not mean that one might go so far as to oppose the creation of surplus embryos?

Still, there is no denying that these medical technologies do exist and that, in cases where natural procreation is impossible or undesirable, there may be moral grounds to justify the development and use of technologies to remedy infertility problems.

It is nevertheless essential that our society continue to question how human embryos and gametes should be treated and what value should be placed on them. In the field of medically assisted procreation, the issues must be weighed within the context of current medical knowledge so that the implications of a decision may be considered. Prohibiting the creation of surplus embryos, for example, would affect the safety of women participating in IVF programs. With each new cycle, these women would have to face the risks and inconvenience of superovulation and egg retrieval, and would have to agree to the transfer of a larger number of embryos and accept the accompanying risks.[586]

The issues must also be considered as part of an ongoing debate because the development of a policy on these important matters calls for education and discussion on a suitably advanced level. We therefore cannot claim to offer in this paper a definitive answer to this social dilemma. Our objectives are to contribute to the debate and to take the current situation into account in an effort to solve urgent problems. The Commission set out on this path by publishing the working papers *Crimes against the Foetus*[587] and *Biomedical Experimentation Involving Human Subjects*.[588]

On the strength of their potential for life and genotype, the Commission has already recognized gametes and embryos as having some moral value. First, it has argued that gametes and embryos should be distinguished from other human cells and tissues: "The first [gametes] are the virtual sources of new human life; the second [embryos] already

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582. The strongest objection to this procedure comes from the Vatican, which holds that recourse to the gametes of a third person "constitutes a violation of the reciprocal commitment of the spouses and a grave lack in regard to that essential property of marriage which is its unity." See Congregation for the Doctrine of the Faith, *supra*, note 490 at 24.

583. See *supra* at 46ff.

584. See Hermitte, *supra*, note 207 at 337.

585. One of the Vatican's objections to in vitro fertilization is based on the fact that it may involve the destruction of some embryos. Congregation for the Doctrine of the Faith, *supra*, note 490 at 18.

586. Especially since the technologies using the natural cycle are still in the experimental stage. See *supra* at 22.

587. *Supra*, note 7.

588. *Supra*, note 7.

have life."[589] Further, in the principles it stated and the limits it recommended in its working paper on experimentation, the Commission accorded the embryo intrinsic value.[590] For example, the Commission proposed that the creation of embryos solely for the purpose of scientific research be prohibited;[591] that the law never treat embryos as mere objects (indeed, the commercialization of embryos would be strictly forbidden); that experimentation be prohibited after the fourteenth day of embryo development; and that experimentation be authorized by a multidisciplinary ethics committee. The Commission also holds the view that the most appropriate way to dispose of surplus embryos resulting from in vitro fertilization is not to destroy them but to donate them to infertile couples or, failing that option, to use them for experimentation to advance knowledge.[592]

The protection afforded embryos is not, therefore, at odds with the creation, freezing or donation of surplus embryos. In fact, one of our recommendations specifically allowed for the freezing of embryos for a period of five years.[593] At this stage in our research, we believe that it is appropriate to reaffirm this position. We do not confirm their legitimacy, but we have no objection to the creation of surplus embryos or to the donation or freezing of gametes and embryos.

I. General Principles

Individual freedom, equality and human dignity[594] are some of the principles and values challenged and sometimes placed in conflict by the various issues associated with medically assisted procreation. Among these issues are access to technologies; the risks of a shift toward eugenic practices; the post mortem commercialization and use of gametes and embryos; and the phenomenon of surrogate motherhood. Meanwhile, the parentage of children born as a result of medically assisted procreation and control over gametes and embryos also raise problems in terms of the possible application by the courts of existing legislation and principles of law. Which values should prevail? What social choices should guide lawmakers? Are there acceptable compromises for Canadian society? What can be done to resolve disputes caused by these technologies? These are some of the questions that will be broached in this chapter.

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589. *Ibid.* at 53.

590. For the various legal conditions imposed on the validity of experimentation and the mechanisms proposed to ensure compliance with these principles, see *ibid.*, rec. 6 at 51.

591. The prohibition led to the recommendation of a criminal sanction: *ibid*, rec. 7(1) at 52.

592. *Ibid.* at 51: "[I]f circumstances do not permit donation, experimentation to advance knowledge seems to be preferable to outright destruction."

593. *Ibid.*, rec. 8(2) at 53.

594. See *Crimes against the Foetus*, *supra*, note 7.

A. Access

In a number of countries, discussion papers have proposed limiting, or legislation has limited, access to medically assisted procreation to stable heterosexual couples who are sterile or infertile or carry a transmissible genetic disorder. The interest of the child (often expressed as the child's right to have a father, a mother and a stable family) and society's interest in protecting the family unit, which is fundamental in our society, are the two arguments most commonly advanced to support such restrictions.

Before it can be determined whether it is necessary and appropriate to entrench such limits in legislation, the above-mentioned criteria must be analysed in terms of the individuals likely to request such medical assistance, and the other values, principles and interests that come into play. For the purposes of this analysis, we considered infertile or sterile persons (physiological infertility), persons who are unable or do not wish to procreate through sexual relations with the opposite sex (social infertility) and persons likely to transmit a genetic disorder (genetic infertility).[595]

Most of those who turn to medically assisted procreation are physiologically infertile. As a rule, the access criteria proposed for these individuals are that they be living as a heterosexual couple and that they be stable. The appropriateness of these criteria is not entirely clear. The criteria of heterosexuality and family status will be discussed later in connection with social infertility; our focus here will be on *stability*.

The criterion of stability, desirable though it may be, raises a number of questions. First, would it be fair to apply this criterion in cases of artificial insemination and in vitro fertilization when the stability of the couple or individual is not a factor in natural procreation, hormone treatment or surgery to correct infertility problems (other forms of medically assisted procreation)? While it is true that the use of gametes from a third person can cause special problems (disclosure of the child's origins and so on), we believe that the objective of using the stability criterion, that is, the welfare of the child, would be more easily attained by ensuring proper support before, during and after the child is conceived.[596] Second, this type of criterion is arbitrary and difficult to evaluate, and because it involves the application of non-medical criteria by health professionals it creates the risk of discrimination.[597] We

595. For the purposes of studying the limitations referred to above, we have to use a definition of infertility broader than the one used in the medical community (see *supra*, chap. 1). This approach is conceived to take into account not only the pathological but also the social aspect of infertility. See The National Bioethics Consultative Committee, *Discussion Paper on Access to Reproductive Technology* (Adelaide: The Committee, 1990) at 8: "Beliefs, social values, expectations and judgements all contribute to the social construction of infertility and to the way we value it and its alleviation."

596. See *infra* at 156-57.

597. See Benjamin Freedman, P.J. Taylor, Thomas Wonnacott and Katherine Hill, "Criteria for Parenting in Canada: A Comparative Survey of Adoption and Artificial Insemination Practices" (1988) 3 C.F.L.Q. 35. The article is the result of a study funded by the Strategic Grants Program in the Human Context of Science and Technology, Social Sciences and Humanities Research Council of Canada; see *ibid.* at 36-37.

therefore feel it would be inappropriate to include in legislation stability — or, for that matter, any other criterion based on parental aptitude — as one of the criteria for determining access to medically assisted procreation.[598]

The situation of people who are physiologically and genetically capable of procreating but for personal reasons cannot or do not wish to do so in the context of a heterosexual union poses a more difficult problem. These people fall into two categories: single people and homosexual people. Access to medically assisted procreation for these people raises the whole question of equality rights[599] as compared to protection of the child and the traditional family. It would be difficult for the state to consider any legislative limit on access to the various technologies used in medically assisted procreation without taking into account the spirit and letter of the *Canadian Charter of Rights and Freedoms*.[600] However, we need only consult various legislative provisions and recommendations made in other countries to see that the special situation of these individuals is rarely accepted as grounds for using medically assisted procreation. In fact many jurisdictions make access to medically assisted procreation conditional on physiological infertility, sterility or the existence of transmissible genetic disorders, or simply limit access to heterosexual couples.[601]

Making access to medically assisted procreation conditional on the existence of pathological conditions (sterility, physiological and genetic infertility) may seem normal, since the technologies were developed to circumvent these problems. However, we cannot ignore the fact that establishing such a condition with respect to artificial insemination[602] would deny access to single people and to homosexual people.[603]

Such limitations therefore raise the question of non-discriminatory access to available medical technologies. This means weighing a number of different interests: on the one hand, the interest of single people and homosexual people who express a desire to have children and to use the available technologies, as would infertile or sterile persons living as part of a heterosexual couple, to overcome the obstacles they face; and on the other, the interest of the child and society's interest in protecting the traditional family with two heterosexual parents.

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598. It should be noted, however, that some reports have taken the opposite position. See, *e.g.* OLRC, *supra*, note 2 at 275: "Eligibility to participate in an artificial conception programme should be limited to stable single women and to stable men and stable women in stable marital or nonmarital unions." The report of the Barreau du Québec, *supra* note 3 at 36, recommends that access be limited to stable couples, married or unmarried. For more details, see appendix A, *infra* at 177.

599. See "Section 15 Equality Rights," *supra* at 92.

600. See *supra* at 82, 88ff, 90, 94 and 96-88.

601. See appendix A, *infra* at 177.

602. We have already stated that in vitro fertilization is different. Unlike artificial insemination, IVF and its derivatives are aimed primarily at female infertility. See *supra* at 98.

603. A legislative limit on access must not create disparity between the groups referred to in s. 15 of the *Charter* or analogous groups. See "Section 15 Equality Rights," *supra* at 92.

The conflict between respect for the rights guaranteed by the *Charter* and protection of the traditional family unit leads to a number of fundamental questions. How far do we wish to go in protecting rights and freedoms, especially the right to equality? How far do we wish to extend the definition of the family? Do we wish to include homosexual families and single-parent families in that definition?

For some, the interest of the child and society's interest in preserving families with two heterosexual parents must take precedence over the fundamental rights of single people and homosexual people. According to this position, having the freedom to choose one's sexual orientation is one thing, but depriving a child of a father and a mother is something else entirely. The technologies used in medically assisted procreation must be used to overcome sterility and infertility (physiological and genetic), not as an easy way out of the consequences of a social choice.

For others, who make the analogy with the criteria used in adoption, these objections are an expression of old prejudices.[604] Furthermore, through the years the state has not intervened to protect the traditional family, the structure of which has been greatly eroded.[605]

Resolving the issue of access to medically assisted procreation technologies thus requires a thorough examination of the family unit at the dawn of the twenty-first century. Are we prepared not only to accept single-parent families and families with two homosexual parents, but also to place them on an equal footing, in terms of our social values, with families with two heterosexual parents? If so, should we not, in the interest of consistency, change our family laws in order to incorporate these new definitions? Or do we wish instead to make protection of the traditional family a public interest that would take precedence over the rights and freedoms guaranteed by the *Charter* and thus limit the right to procreate as we limit the right to marry in our society?

In considering these questions, we could draw on similar situations in the area of "natural" procreation, where single-parent families and families with two homosexual parents are a reality.

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604. See *supra* at 96-98; and Knoppers, *supra*, note 284 at 216: "It is ironic that while adoption laws are being relaxed in order to permit unmarried individuals of either sex to adopt, social prejudices are preventing single women from having access to techniques that would enable them to bear and give birth to children that may in some cases be at least 50 per cent genetically their own." See also *supra*, notes 466 and 467.

605. A recent decision by the Federal Court of Appeal in a matter involving labour relations reversed a ruling by a federal human rights tribunal that in effect broadened the definition of family to include homosexual couples. The tribunal's ruling followed a complaint under the *Canadian Human Rights Act*, *supra*, note 454. See *Mossop*, *supra*, note 458 at 35: "Even if we were to accept that two homosexual lovers can constitute 'sociologically speaking' a sort of family, it is certainly not one which is now recognized by law as giving its members special rights and obligations."

For the moment, taking current social conditions into account, the Commission is of the opinion that with regard to artificial insemination, protection for the traditional family should not be incorporated in legislation at the expense of the right to equality.[606] Moreover, given the nature of artificial insemination, we believe that state intervention in this area should be kept to a minimum.[607] With respect to in vitro fertilization, the issue of the right to equality creates few problems.[608] However, since these technologies raise the question of the allocation of scarce and costly resources, a legislative limit on access could prove necessary. In any event, caution dictates that such action be taken in accordance with the principles of fundamental justice.[609]

Finally, the use of medically assisted procreation by persons who are physiologically capable of procreating but are carriers of a genetic disorder leads to the question of choosing which genetic disorders justify access to medically assisted procreation, and of which gametes and embryos should be considered "acceptable." There is a risk, in making such choices, of opening the door to eugenic practices. This concern also raises another issue, namely, the selection of donors or donor characteristics.

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606. In October 1988, the Spanish parliament passed a law on medically assisted procreation under which access is not limited to married couples. Single women and women cohabiting with men are eligible. See appendix A, *infra* at 177-78. OLRC, *supra*, note 2 at 157: "[A] majority of the Commission has come to the conclusion that, while participation in an artificial conception programme should not be a right given to every infertile or genetically diseased person or couple wishing to have a child, eligibility for participation should not be restricted to married couples or, indeed, even to couples." The OLRC states in its first recommendation (at 275) that the technologies should be used only for medical reasons, except in the case of single women who are fertile and genetically healthy. The report of the Ministère de la Santé et des Services sociaux, *supra*, note 504, s. 11, states at 176 that artificial insemination must be available to single women regardless of their status. Canadian Bar Association, *supra*, note 278 at 22: "After much discussion, the committee concluded that there was no need to legislate criteria of eligibility. While this might leave the situation open to personal prejudices of the treating physician, the committee further concluded that present legislation prohibiting discriminatory practices should provide sufficient protection." In Sweden, on the other hand, the technologies are available to married or cohabiting couples only, and the husband's consent is required; see appendix A, *infra* at 177-78, note 55. The Norwegian parliament has adopted a law regulating AI and IVF that limits access to married couples who have given their consent and have undergone a medical and psychosocial examination by a physician; see appendix A, *infra* at 177-78, note 56. Council of Europe, *Human Artificial Procreation* (Strasbourg: The Council, 1989) at 17:

> After careful examination of these arguments, realising the medical nature of these techniques and taking into account the importance of ensuring the welfare of the future child, the committee reached the conclusion that the availability of the artificial procreation techniques should be limited to heterosexual couples with a medical need. This determination intends to eliminate the cases where the future child would inevitably be born as an "orphan."

For more details about the position of other countries and states, see appendix A, *infra* at 177-78. For the reports that have limited access to infertile persons and persons at risk for transmitting genetic disorders to their children, see appendix A, *infra* at 178.

607. See *supra* at 90.

608. See *supra* at 98.

609. See *supra* at 89ff.

Using medically assisted procreation technologies to avoid transmitting a genetic predisposition or a characteristic trait that is deemed undesirable[610] or to choose the sex or select the desired qualities of the unborn child is unacceptable.[611] In more general terms, such practices lead the way to the development of a traffic in gametes and embryos with particular qualities,[612] breed intolerance of human imperfection and disrupt the demographic and social balance between the sexes for future generations, and could have a tremendous impact on these "made-to-measure" children. It therefore seems appropriate to generally limit individual freedoms in the name of respect for human dignity.

What genetic disorders justify the use of medically assisted procreation? This question can be answered indirectly by permitting the selection of gametes and embryos for specific qualities only in situations where the goal is to prevent the transmission of a serious genetic disease. Limiting the selection of donors and donor characteristics would also discourage unwarranted use of the available technologies.

It is one thing to allow the medical profession to address, as much as possible, the concerns of couples about the homogeneity of the family unit; it is quite another to allow couples to ask for particular donor characteristics or for the manipulation of gametes and embryos so that the child fits the stereotypes of society or satisfies the whims of the future parents, and the Commission is not prepared to recommend such a step.[613] It is therefore important that the description of the donor's characteristics be limited to essential details and that identification of the specific features of gametes and embryos be permitted solely to prevent the transmission of a serious genetic disease.[614] For example, it would be acceptable in cases where the purpose of sex determination would be to prevent the conception of a child with a sex-linked disease such as hemophilia.

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610. "Characteristic trait" is opposed here to serious genetic diseases such as Tay-Sachs disease, thalassemia, Duchenne muscular dystrophy, hemophilia and Huntington's disease.

611. C. Overall, "Introduction" in Overall, ed., *supra*, note 129, 1 at 18:

> A significant effect of reproductive technologies is that they seem to enable us to make more and more detailed specifications of what kinds of children we do and do not want to have. The apparently innocent goal, the positive goal, of having strong, healthy, thriving offspring, changes into a more negative goal of avoiding or getting rid of children with certain supposedly undesirable characteristics.

See appendix A, *infra* at 178-79.

612. The Repository for Germinal Choice in California, otherwise known as the "Nobel Prize sperm bank," is one example. See Arthur Caplan, "California Sperm Bank Is a Loony Notion" *The [Montreal] Gazette* (24 November 1989) B-3: "The bank claims to have deposits in its fridge from noteworthy scientists, some corporate success stories and at least one Olympic athlete. Nearly 100 babies have been created using sperm from the Repository for Germinal Choice. Couples who want to obtain sperm must be married and must show themselves to be persons of achievement and ability."

613. See appendix A, *infra* at 178-79.

614. See the report of the Ministère de la Santé et des Services sociaux, *supra*, note 504 at 65; see also appendix A, *infra* at 179.

In order to ensure compliance with these limits, the activities of banks and infertility clinics and the import of gametes and embryos must be controlled. And if they are to be effective, the limits must be applied uniformly throughout Canada.

RECOMMENDATIONS

1. Legislation governing access to medically assisted procreation technologies should respect the right to equality. Access should be limited only in terms of the cost and scarcity of resources. Where limitation is necessary, selection should not be based on unlawful grounds for discrimination within the meaning of federal and provincial legislation (family status, marital status, sexual orientation, and so on).

2. To eliminate the possibility of eugenic practices, the selection of gametes and embryos with specific qualities should be prohibited, except where the objective is to prevent the transmission of serious genetic diseases.

B. Commercialization

The existence of surplus embryos, and the donation, storage and import of gametes and embryos make the possibility that these genetic products may be considered objects of commerce[615] an attractive one. Society is thus forced to question the very nature of these products and consider a new definition of the person in law, namely, what can be deemed an object of commerce, or reified.[616]

Modern medicine has brought a new dimension[617] to the commercialization of the human body and its products and substances. The U.S. case of *Moore* v. *Regents of the*

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615. See *supra* at 40.

616. Bernard Keating, "Le statut moral de l'embryon humain: une approche attentive à la question des fondements de l'éthique," unpublished doctoral thesis, Quebec, Graduate School of Laval University, 1990 at 138-40:

> [TRANSLATION]
> Questioning the status of the human embryo means drawing a line between persons and things. This distinction is essential, as we dispose of things and respect persons. Things have a price; persons are priceless. To consider embryos as persons would be to acknowledge the limits of our ability to treat them as we see fit. It is established that a person can never be the mere means to an end. The stakes are very high. . . . Does accepting to treat human life, amid the obscurity of its origin, as an object not imply that a less than absolute respect for the person has already been accepted?

617. On the question of the commercialization of human organs, see *Procurement and Transfer of Human Tissues and Organs*, *supra*, note 250.

University of California[618] provides ample evidence of the complexity of the problems created by commercialization.[619]

The unique nature of gametes and embryos, as noted by the Uniform Law Conference of Canada, which excludes them from its definition of tissues,[620] raises a number of questions. While the nature and use of gametes and embryos raises issues pertaining to human dignity and leads us to reflect upon the moral or symbolic value to be accorded these genetic substances and upon the reification of the human being, the commercialization of gametes and embryos poses a similar problem of safety both for the woman in whom they are implanted and for the future child. Finally, commercialization has a bearing on freedom of commerce.

1. Embryos

Commercialization of the embryo must be prohibited outright for this purpose, as it should be for experimentation.[621] Treating the embryo as a thing that is an object of commerce and including it in the consumer market constitute a direct assault on human dignity.[622] But assuming that the embryo may be the object of a limited number of legal

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618. 249 Cal. Rptr. 494 at 498, 504 (Cal. App. 2d Dist. 1988):

> This appeal raises fundamental questions concerning a patient's right to the control of his or her own body, and whether the commercial exploitation of a patient's cells by medical care providers, without the patient's consent, gives rise to an action for damages. This appears to be a case of first impression. . . .
>
> We have approached this issue with caution. The evolution of civilization from slavery to freedom, from regarding people as chattels to recognition of the individual dignity of each person, necessitates prudence in attributing the qualities of property to human tissue. There is, however, a dramatic difference between having property rights in one's own body and being the property of another. . . . We are not called on to determine whether use of human tissue or body parts ought to be "gift based" or subject to a "free market." That question of policy must be determined by the Legislature. In the instant case, the cell-line has already been commercialized by defendants. We are presented a *fait accompli*, leaving only the question of who shares in the proceeds.

This ruling was partly upheld by 793 P. 2d 479 (Cal. 1990). The part of the ruling dealing with the general principle recognizing the patient's rights to control his or her own body was upheld. However, the principle was based merely on the doctrine of informed consent and the nature of the physician-patient relationship. For more details, see *Procurement and Transfer of Human Tissues and Organs*, *supra*, note 250.

619. Legal thought on the subject is developing rapidly at present, and the diversity of the solutions proposed is a clear sign that development must continue. For example, the theory of attribution put forward by Jean-Christophe Galloux in "De la nature juridique du matériel génétique ou la réification du corps humain et du vivant" (1989) 3 R. recherche jur. 1 at 1-31, implies an absolute but functional notion of the extra-commerciality of the human body. Hermitte concludes that a new category is needed and proposes the category of "things of human origin intended for human use." She subdivides products of the human body into "products that are not objects of commerce," "products that are not objects of exchange," "objects of remunerated exchange," "commodities," etc. See *supra*, note 207 at 325.

620. *Uniform Human Tissue Donation Act* (1989), *supra*, note 236; see *supra*, note 237. See also the opinion expressed by the Commission, *supra* at 122-23.

621. *Biomedical Experimentation Involving Human Subjects*, *supra*, note 7 at 49.

622. *Ibid.*

transactions, we must make certain that it does not become a commodity, at the mercy of the laws of supply and demand.[623]

2. Gametes

Making gametes mere objects of commerce may also violate the fundamental notion of human dignity. The specific nature of gametes (virtual sources of life) and the objective of gamete donation (allowing infertile people to become parents) are ill-suited to commerce in our society. The donation of gametes must remain an altruistic act. Moreover, competition between banks may lead to eugenic practices. For example, there is the risk of banks attracting and accepting only donors with certain qualities or characteristics that are deemed more desirable than others, thereby responding to a commercial stereotype of the ideal male parent.[624] To attain these objectives, a bank might, for example, pay a donor on the basis of his characteristics. Even if the couple were not allowed to determine what characteristics they wanted, the reputation of some banks for the "quality" of their donors could have the same result: a form of eugenics would be practised.[625]

Further, commercialization of gamete donation may compromise the "quality" of the gametes used. Monetary incentives increase the risk of donors failing to disclose some or all of the information needed to assess their suitability.[626] Moreover, the desire of banks to maximize their profits may have an adverse effect upon medical screening and selection.

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623. See Evelyne Shuster, "Seven Embryos in Search of Legitimacy" (1990) 53:6 Fertil. Steril. 975 at 977:

> [A] position most widely held is that embryos have only special or limited interests in life and thus should not be treated as actual persons with full moral rights. However, because they are potential persons, the embryos belong to the order of being and not of having. They are neither things nor properties. They cannot be bought, sold, or returned. Individuals do not have ownership rights to do whatever they want with them.

624. Council for Science and Society, *supra*, note 533 at 41-42:

> If commercial sperm banks were set up (as has already happened in the USA) this could give rise to some objectionable practices. Highly "desirable" donors might be tempted to sell their semen for large sums of money. Sperm from Nobel prize winners is already advertised in the USA, playing on people's desire to be parent to a genius and ignoring the adverse factor of sperm from ageing men.

625. *Biomedical Experimentation Involving Human Subjects*, *supra*, note 7 at 53-54: "The Commission is of the opinion that new recommendations concerning not only sperm banks but embryo banks as well should be drawn up, so as to establish clear and precise standards, and guard against the drawbacks and dangers of uncontrolled expansion and commercialization of such banks."

626. OLRC, *supra*, note 2 at 169:

> [W]e are also of the opinion that the need for a sound family history, and for information concerning whether a donor has contracted a sexually transmitted disease between the initial genetic screening and the donation, compels the conclusion that donors should not be induced to donate gametes by the lure of a reward, lest they suppress important information about themselves. The risk of such suppression, and its cost to those upon whom the burden will fall, outweigh any benefit achieved by permitting unrestricted payments.
>
> Accordingly, the Commission recommends that individual donors of sperm should be allowed to be paid their reasonable expenses.

See also *ibid.*, rec. 15 at 276.

Thus, the possible assault on human dignity and the risks inherent in commercialization warrant the limitation of individual freedoms, in particular, freedom of commerce. However, since people may not be willing to come forward unless their expenses are covered, reasonable expenses incurred by donors should be reimbursed.[627]

Finally, in view of the need to ensure optimum quality of genetic screening and selection, banks should be able to be reimbursed for reasonable costs related to their operations.[628]

RECOMMENDATION

3. (1) All commercialization of the donation of gametes and embryos should be prohibited. Only reimbursement of reasonable expenses incurred by donors should be permitted.

(2) Gamete and embryo banks should not be permitted to operate on a profit basis. However, banks should be allowed to be reimbursed for reasonable costs related to their operations.

C. Surrogacy

We must state at the outset that incidence of the phenomenon of surrogate motherhood is very difficult to evaluate. A study of surrogacy practices carried out in the summer of 1988 for the Law Reform Commission of Canada found:

> The major finding of this study is that preconception contracts involving Canadians are a phenomenon of very moderate scope but considerably more frequent than all of the people (with one exception) with whom we talked and who considered themselves knowledgeable in the area estimated. Taking our low overall estimate (i.e., allowing only 11 cases for Quebec) we end up with a grand total of 104 cases in Canada. Taking our higher estimate (allowing 25 cases for Quebec) we end up with a total of 118 cases.
>
> Either estimate greatly exceeds what was quoted to us as a reasonable estimate for the overall incidence. In order to appreciate this finding, it must be remembered that we have been extremely stringent in excluding cases if there was any doubt concerning them. We thus feel confident that these numbers represent a very conservative estimate which probably greatly underestimates the real extent of the phenomenon.

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627. In the same vein, see appendix A, *infra*, notes 65 and 66 at 179. See also *An Act to amend the Uniform Child Status Act*, *supra*, note 199, s. 11.5; see *supra*, note 253.

628. See appendix A, *infra*, note 67. However, the OLRC report, *supra*, note 2 at 172, would allow banks to make some profit; see appendix A, *infra* at 180.

> We also conducted an analysis of socio-economic characteristics of contractual mothers, fathers, and fathers' wives utilizing Keane's agencies. Overall, contractual mothers belong to a lower social class than fathers and fathers' wives. It cannot be assumed that this analysis tells us anything about the participants in informal preconception contracts. We do not have sufficient information to make educated guesses about the socio-economic characteristics of this latter group of people.[629]

Even setting aside the contractual[630] and commercial aspects of surrogacy, the use of surrogates is the subject of much controversy. Uncertainty about the impact of the practice on the parties involved — especially the surrogate and, most of all, the child — raises major concerns about possible psychological risks.[631] While the use of a family member or friend as a surrogate may be less shocking to some, the risks remain. The relationship between the parties may even complicate the outcome. The child may also be exposed to significant physical risks if the surrogate, knowing she has to surrender the child at birth, acts in a negligent manner and fails to take the precautions needed to create the healthy environment that is vital to normal development of the fetus.

There are some who feel that, beyond these questions of safety, surrogacy contravenes the fundamental values of our society, in particular human dignity and the protection of the traditional family.[632] They argue that the use of a surrogate dehumanizes maternity, devalues gestation[633] and violates the child's right not to be treated as a thing that can be the subject-matter of a contract. Deliberately conceiving a child in order to surrender it to a third person at birth indicates a lack of respect for the unborn child and for life itself. Some argue in the name of these greater interests that individual freedoms should be limited and that surrogatehood in any form should be prohibited.

For others, the psychological risks, while they are serious, amount to nothing more than speculation, given the lack of knowledge about the true nature of the bond that is established during gestation.[634] This argument, therefore, cannot be used as grounds for

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629. Eichler and Poole, *supra*, note 530 at 45-46. The study shows very clearly, at least, that the phenomenon is shrouded in secrecy and extremely difficult to evaluate; an appendix includes a series of very interesting tables.

630. We saw in chap. 2 that, as the law currently stands, the contractual aspect of surrogate motherhood runs counter to the principles of contract law and family law; see "Legality and Legitimacy," *supra* at 65 and "The Enforceability of Surrogacy Contracts," *supra* at 84.

631. These arguments have been made by the OLRC, *supra*, note 2 at 230. See also Barreau du Québec, *supra*, note 3 at 28; and Warnock Report, *supra*, note 421 at 45.

632. See, *e.g.*, Barreau du Québec, *supra*, note 3 at 28. See also A.M. Capron and M.J. Radin, "Choosing Family Law over Contract as a Paradigm for Surrogate Motherhood" (1988) 16:1-2 Law Med. Health Care 34 at 36-37.

633. Baudouin and Labrusse-Riou, *supra*, note 210 at 111: [TRANSLATION] "Gestation is thus no longer a step in the establishment of a permanent mother-child relationship. It is reduced to a temporary function of production. It does not serve to create an emotional bond, but is used merely as a form of technical support." See Barreau du Québec, *supra*, note 3 at 29.

634. See OLRC, *supra*, note 2 at 231.

prohibition. The physical risks could be controlled by giving proper medical attention,[635] possibly mandatory, to the surrogate. Regarding the risks to the institution of the family, not everyone is convinced that surrogate motherhood represents an injurious infringement.[636]

We may not be in a position to assess the psychological impact of surrogate motherhood, but it does not take a comprehensive study to conclude that caution is needed. While control of surrogate motherhood may reduce the physical risks, regulation would imply state approval and the legitimization of surrogacy agreements.[637] As noted earlier,[638] endorsing surrogacy contracts would be at odds with a fundamental principle of family law: custody of a child must be determined according to the child's best interest and not the wishes of the parents as expressed in a contract.

The principle of human dignity leads us to conclude that a child cannot be the subject-matter of a contract and must under no circumstances be treated as a thing.[639] This principle should take precedence over individual freedoms. Treating a child in any other manner could change our perception of the human being. Provisions should perhaps be made at the national level to express this fundamental value in such a way that it cannot be challenged and to discourage all activity related to surrogate motherhood.[640] Accordingly, surrogacy agreements should not be recognized in law: they must remain absolutely null and void.[641] This conclusion is consistent with the existing principles of contract and

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635. *Ibid.*

636. *Ibid.* at 232. See Canadian Bar Association, *supra*, note 278 at 28: "The committee was not convinced that recognition of surrogacy agreements would undermine stability of the family."

637. See Warnock Report, *supra*, note 421 at 46-47.

638. See *supra*, note 630.

639. See *supra* at 40-41 and in particular note 209.

640. R. Alta Charo, "Reproductive Technologies and Bioethics in the United States: Looking Back, Looking Ahead" in Christian Byk, ed., *Artificial Procreation: The Present State of Ethics and Law* (Lyon: Lacassagne, 1989) 249 at 255: "In fact, following the controversial Baby M case, the legislative trend in the U.S. appeared to veer towards prohibition and away from the relatively supportive early state statutes in Arkansas, Kansas, and Nevada, which had regularized portions of the procedure without explicitly approving it or making the contracts enforceable." The New York State Task Force on Life and the Law, *Surrogate Parenting: Analysis and Recommendations for Public Policy* (New York: The Task Force, 1988) at 127:

> Given the potential risks to the children born of surrogacy, children are best served by policies designed to discourage the practice.
>
> The Task Force members feel deep sympathy for infertile couples, many of whom experience a profound sense of loss and trauma. Nevertheless, the Task Force concluded that society should not support surrogacy as a solution. The practice will generate other social problems and harm that reach beyond the infertile couples who seek a surrogate arrangement.

641. Similarly, see appendix A, *infra* at 180-82, note 76, and table 4 at 210-13. However, Ontario (OLRC, *supra*, note 2 at 233) opted for regulation of surrogacy. The Canadian Bar Association (*supra*, note 278 at 29) commented as follows on the system proposed by the OLRC:

family law. The interest of the child must remain the basis for any decision respecting custody, and freedom of contract must be limited accordingly.[642]

The commercial aspect of surrogacy agreements raises various questions for society. For some, the idea that a woman might rent her womb is an affront to human dignity and integrity.[643] Others point to the possibility of disadvantaged women being exploited by women with economic power. Surrogacy agreements are also thought to be degrading for the child, who is exchanged for a sum of money and treated as a mere object of commerce. Putting a monetary value on a child is harmful not only to the child but also to society. The commercial aspect of surrogacy breaches a fundamental value: the human being is not an object of commerce.[644]

In terms of a regulatory scheme, the committee considered the approach recommended by the Ontario Law Reform Commission, which proposed a system of prior judicial screening and approval, as opposed to the traditional ex post facto review. The committee concluded that such a system was too cumbersome and likely not to be followed, even if legislated. It would establish a separate system for a type of assisted reproduction, something that should be avoided in principle unless good reason exists. The fact in these arrangements of deliberately creating a child for the purpose of surrendering its care to another is not sufficient distinction to warrant development of a unique approach and scheme. The committee has noted that most jurisdictions that have legislated in this area have maintained the traditional ex post facto review.

> "Surrogacy" arrangements should be assimilated as much as possible into the existing model for adoptions.

The Canadian Bar Association, *ibid.* at 30 recommends "not to encourage surrogacy but to facilitate it in rare circumstances when the birth mother chooses to honour the agreement in a situation that gives every possible protection to herself."

642. See "Legality and Legitimacy," *supra* at 65 and "The Enforceability of Surrogacy Contracts," *supra* at 84.

643. See Warnock Report, *supra*, note 421 at 45.

644. This view is reflected in most jurisdictions around the world. See appendix A, *infra* at 180-82 and table 4 at 210-13. R. Alta Charo, "Surrogate Parenting: Analysis and Recommendations for Public Policy" (1989) 10:1 J. Leg. Med. 251 at 255: "The OTA report documents that commercial surrogacy has been disapproved in every governmental report in the world except that of the Ontario Law Reform Commission." In April 1990, The National Bioethics Consultative Committee in Australia released its first report on surrogate motherhood: The National Bioethics Consultative Committee, *Surrogacy, Report 1* (Adelaide: The Committee, 1990) at 36:

> 6.4 It is therefore recommended that:
> (a) Surrogacy should not be totally prohibited.
> (b) Surrogacy should not be freely allowed.
> (c) Surrogacy practice should be strictly controlled by uniform legislation.
> (d) Uniform legislation should include the following:
> (i) All surrogacy agreements be rendered unenforceable
> (ii) Controlling mechanisms for agencies
> (iii) Advertising controls.

See also The National Bioethics Consultative Committee, *Discussion Paper on Surrogacy 2 — Implementation* (Adelaide: The Committee, 1990).

Individual freedoms are often restricted in similar circumstances.[645] For example, adoption and child protection laws specifically prohibit the sale of children.[646] However, even if such provisions were applicable to children born of surrogates, they might not apply to the sale of children outside the context of adoption.[647] Because the existing provisions apply only where the transaction is intended to result in the adoption of a child,[648] if no petition for adoption is brought to establish parentage,[649] no one can be prosecuted. Further, even where a petition for adoption is filed, if the judge is not apprised of the fact that an exchange of money occurred previously, the transaction goes unpunished.

Prohibiting the sale of human beings is a fundamental value that, being a matter on which there is consensus, must influence the law. The role of lawmakers is to take action that at a given time unambiguously expresses society's values and views on such a fundamental issue.

The argument that surrogacy does not constitute the sale of a child but rather payment for a service does not withstand scrutiny because the intended result and purpose of the surrogacy agreement is to transfer custody of the child. In surrogacy, unlike in adoption, the child is conceived specifically to be surrendered in return for a sum of money. It should be remembered that the payment often represents more than the expenses incurred. Further, the role played by intermediaries and the fees they are paid emphasize the commercial aspect of the transaction. Even if the transaction were not the sale of a child, the result would be too much like a sale to be treated differently. Any attempt to commercialize

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645. Even those who advocate protection of the right to procreate generally feel that protection does not extend to the commercial aspect. See, *e.g.*, Charo, *supra*, note 310 at 108:

> As a commercial ban interferes only with an asserted right to pay for surrogacy, not with the right to procreate, and as women's self-reported motivations for becoming surrogates usually include non-commercial considerations, such as a desire to help other people, a commercial ban should be upheld as a rational expression of state interest that does not unduly interfere with the right to procreate. This conclusion is shared by at least two state courts.

It should be remembered that in *Baby M* (*supra*, note 302), the Supreme Court awarded custody of the child to the father of the child and granted visitation rights to the surrogate mother, but also ruled as follows:

> We invalidate the surrogacy contract because it conflicts with the law and public policy of this State. While we recognize the depth of the yearning of infertile couples to have their own children, we find the payment of money to a "surrogate" mother illegal, perhaps criminal, and potentially degrading to women. [at 1234] ... This is the sale of a child, or, at the very least, the sale of a mother's right to her child, the only mitigating factor being that one of the purchasers is the father. Almost every evil that prompted the prohibition on the payment of money in connection with adoptions exists here. [at 1248] ... In sum, the harmful consequences of this surrogacy arrangement appear to us all too palpable. In New Jersey the surrogate mother's agreement to sell her child is void. Its irrevocability infects the entire contract, as does the money that purports to buy it. [at 1258]

See also *Doe* v. *Kelley*, *supra*, note 310.

646. See *supra* at 67-69 and note 309.

647. See *supra* at 68.

648. Except for Manitoba; see *supra*, note 311.

649. See "Legal Parentage," *supra* at 69.

surrogacy (payment to surrogates and intermediaries) should be expressly prohibited. A recommendation to this effect would follow the logic of the prohibitions that currently apply to adoption and child protection.[650] Given the nature of such a prohibition and the need for uniform intervention, the Commission feels that the *Criminal Code* may be the right medium.[651]

However, while the commercial aspect of surrogate motherhood merits prohibition, the Commission feels that subjecting the infertile couple, who have already experienced the anguish of infertility, and the surrogate, who is trying to provide a solution to their problem, to the stigma of criminality and the ensuing consequences seems excessive and might still not dissuade couples who are only seeking to realize a legitimate desire. A criminal prohibition could drive the entire practice of surrogacy underground, with all the risks that entails.[652] Under-the-table agreements increase the possibility of irresponsible practice and make recourse to the courts virtually impossible because of the fear of reprisals. Such intervention could therefore prove very damaging for the child both physically and psychologically. Subjecting the parties immediately involved (the surrogate, her spouse and the social parents) to criminal prosecution could thus do more harm than good. Even if their actions are reprehensible, we are not convinced that it is appropriate to subject the parties to criminal proceedings. A total prohibition would not contribute adequately to the search for a solution to the problem and would not be warranted in terms of the principles of criminal law.[653] In any event, such a prohibition would certainly not be in the interest of the already-conceived child. Who should be given custody of the child once the parents have been prosecuted, found guilty and possibly imprisoned?

To ensure greater effectiveness in attaining the desired goal (preventing the development of a "child market" and discouraging people from engaging in traffic in children), the Commission is of the opinion that the *Criminal Code* should prohibit activity by paid intermediaries. Since paid intermediaries are the ones who create, set the conditions for and encourage such a market, discouraging people from engaging in activity of this nature would have a tremendous impact on the commercialization of surrogate motherhood. By not being subject to criminal sanctions, the immediate parties would be encouraged to lay charges against intermediaries. People would be dissuaded from engaging in such trade,

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650. See "Commercial Aspects of Surrogacy," *supra* at 67 and "The Enforceability of Surrogacy Contracts," *supra* at 84. It should be borne in mind, however, that Ontario and British Columbia permit some payments in adoption cases under certain conditions. In British Columbia, payment would be possible if it were authorized by a court of law; see *Adoption Act*, *supra*, note 309, s. 15.1. For Ontario, see *Child and Family Services Act, 1984*, *supra*, note 309.

651. *Our Criminal Law*, *supra*, note 580. As we have seen, however, current provisions of the *Criminal Code* do not cover the phenomenon adequately. See *supra* at 69.

652. Regarding obstacles to the effectiveness of legislative intervention, see Kidder, *supra*, note 9 at 112ff., at 117: "[S]udden legal changes don't always produce the results intended by the judges or lawmakers. . . . Sometimes laws which were passed to produce one effect end up having either unintended side effects or opposite effects from those intended." On the phenomenon of those covered by a law changing the impact of that law, see in particular *ibid.* at 136-37.

653. See *Our Criminal Law*, *supra*, note 580 at 33.

as the risk to intermediaries would be too high: a conspiracy of silence would not protect them. Before becoming involved in such activities, intermediaries would have to consider the fact that they could well face charges (if, for example, the surrogate conducted herself improperly during the pregnancy, if she refused to surrender the child at birth, or if the social parents refused the child).

Preventing the commercialization of surrogate motherhood is a desirable objective, and if it is to be achieved legislative intervention is needed. However, consideration must be given to the real impact of such intervention and other equally important factors, such as the safety of the child. A total ban on surrogacy could give the impression that the problem was resolved, but this would not be the case. We believe it is more realistic and effective to stop only the activities of paid intermediaries than to try to prevent all surrogacy agreements between individuals. Such a position would bring Canada in line with the vast majority of the countries that have considered the matter.[654]

RECOMMENDATION

4. Surrogacy contracts must remain absolutely null and void. Further, acting as a paid intermediary in such an agreement should be a criminal offence.

The preceding recommendation is not unanimous. According to the minority view, it is both inappropriate and inefficient to criminalize only the remuneration of intermediaries in surrogacy arrangements. In the opinion of the minority, either of two alternative approaches would be more appropriate than that favoured by the majority.

The object of the proposed criminal prohibition is to stigmatize traffic in human beings. Commercialized surrogacy is seen by the majority as a form of trafficking in babies that should be prohibited. The situation is not really different from that in which people engage in the buying and selling of children already born. The anguish of infertility and the burden of carrying the child do not alter the reprehensible character of the activity. These factors may justify leniency in sentencing, but they do not exonerate the parents or the surrogate from criminal culpability. If the activity is considered sufficiently reprehensible to warrant criminal sanction, then the minority feel that, logically, all parties who engage in it should be subject to that sanction.

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654. Charo, *supra*, note 310 at 108. See, *e.g.*, the *Surrogacy Arrangements Act 1985*, *supra*, note 421, which prohibits surrogacy on a commercial basis and criminalizes the activities of specialized agencies or other third parties. The statute does not prohibit all forms of payment to the surrogate. The Warnock Report, *supra*, note 421 at 46-47, calls for sanctions for intermediaries and professionals, whether they operate for profit or on a non-profit basis. The United Kingdom White Paper does not share this view, however. Department of Health and Social Security, *Human Fertilisation and Embryology: A Framework for Legislation* (London: HMSO, 1987) para. 73 at 12: "The Government does not however consider that it is appropriate, nor necessarily in the child's best interests, to bring the practice of surrogacy other than the operation of commercial agencies within the scope of the criminal law and the Bill will not add to the criminal sanctions contained in the 1985 Act." For more details, see appendix A, *infra* at 180 and table 4 at 210-13.

According to the minority, however, simple refusal to accord legal recognition to any contractual arrangements relating to surrogacy would be more effective than criminal prohibition as a means of discouraging surrogate motherhood. All such contracts should be regarded as contrary to public policy and therefore be treated as void *ab initio*. If this were done, there would be two key consequences. First, there would be a presumption that the child is the natural child of the gestational mother. The social parents would have no recourse against her if she were unwilling to surrender the child. Second, intermediaries would not be able to collect any payment for the services they provide, and they could be compelled to refund any payment received. The risk of such an outcome would greatly discourage people from entering into any kind of surrogacy arrangement, especially one involving the payment of money. Such a regime could be supplemented by regulatory offences carrying substantial fines or other penalties. This would constitute an effective deterrent to anyone engaging in commercialized surrogacy.

D. Control over Gametes and Embryos

The question of control over genetic products and the limits to be imposed creates problems in terms of both application of existing legislation and principles of law, and respect for the fundamental principles and values of our society, in particular, individual freedoms and human dignity.[655]

The following remarks are made in a context where the technologies used in medically assisted procreation are not yet sufficiently advanced to prevent the creation of surplus embryos. In the long term, we can only hope that this problem will be resolved, but refusing to consider it today on the grounds of moral or ethical principles would in our view be unrealistic.[656]

Uncertainty about the fate of frozen gametes and embryos when, for example, a couple divorces or a dispute arises (whether between partners or between the bank and its clients) and about the nature of the producer's control over his or her gametes, as well as embryos created with them, has given rise to legal disputes for which the law as it currently stands offers no solution. Who has control? What is the basis for that control? In what way is the control restricted? And what limits apply to the way gametes and embryos can be used? Recent case law[657] indicates that the courts are quite embarrassed when asked to decide the fate of frozen gametes and embryos in circumstances of this nature. The rulings also bear witness to the difficulties and risks encountered when such disputes are left entirely to the judicial system. In the *Parpalaix* case,[658] for example, we saw that the central issue, namely the post-mortem use of gametes, was avoided. The ruling of the trial judge in

655. See Council of Europe, *supra*, note 606 at 11.

656. See *supra* at 122-23.

657. See *supra*, notes 202-204.

658. *Supra*, note 202.

the *Davis* case[659] in the United States illustrates the dangers of absolutism where the status of the embryo is concerned. Finally, it is difficult to accept that a couple should have to seek permission from the courts in order to be able to use their embryos for procreation.[660] The question of control over gametes and embryos therefore creates problems that demand a solution. What legal regime should apply?

1. Embryos

The nature of the embryo makes it difficult to determine its status (Is it a person or a thing?) and whether it falls into the private realm of property law or the public realm of the law of persons (who cannot be objects of commerce).[661] Given this impasse, how can the problem of control over the embryo be resolved?

A number of solutions are possible. The lawmaker could create a category for the embryo that would lie between things and persons; adopt rules of law that would borrow from both categories;[662] make the matter subject to the rules of property law;[663] impose a solution to any possible dispute (donation to third persons, destruction or experimentation) through regulation of banks;[664] or refrain from intervening but ensure that the consent of those with control makes provision for the fate of the embryos in specific situations.[665]

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659. *Supra*, note 203 at 2. Among the reasons for the decision by Judge Dale W. Young were the following: "(7) Human life begins at conception. (8) Mr. and Mrs. Davis have produced human beings, *in vitro*, to be known as their child or children." For a critical review of this position, see Shuster, *supra*, note 623 at 976ff.

660. *York* v. *Jones Institute*, *supra*, note 204. See *supra*, note 217.

661. See Keating, *supra*, note 616.

662. Catherine Labrusse-Riou, "Réflexions terminales" in Raphaël Draï and Michèle Harichaux, eds, *Bioéthique et droit* (Paris: P.U.F., 1988) 269 at 275: [TRANSLATION] "It is important that positive law preserve its categories of 'person' as opposed to 'thing', or the notion of civil identity defined by the category 'status of the person,' which cannot be disposed of; but within these categories, one should be imaginative in trying to find rules which themselves can change to accommodate these new situations we face." Louisiana recognizes fertilized ova as having "legal personality" until it is implanted in the uterus. As a "legal person," a fertilized ovum cannot, therefore, be considered property and could take or be the subject of legal action. The gamete donors are considered to be its parents; failing this, the medical clinic is designated the guardian of the conceptus. From this designation stems the prohibition against destroying an in vitro embryo that has the potential to develop normally. Although the conceptus has "legal personality" before it is implanted, its inheritance rights do not come into being until its birth and will be bound to the "natural" or adoptive parents (see appendix A, *infra* at 182). In France, the National Ethics Committee has termed the human embryo a "potential person" and therefore subject to the law of persons, not property. See Labrusse-Riou, *ibid.* at 273. Knoppers, *supra*, note 221 at 343ff. The article points out that the recommendations of U.S., European and Commonwealth law reform commissions indicate a consensus on the need to protect genetic material but do not necessarily grant it legal personality.

663. The intentions of the "owners" would prevail. Agreements so signed would have to be respected by divorce law and the law of successions. It would also be possible to make the contract of deposit binding.

664. See Conseil d'État, "Avant-Projet de Loi sur les sciences de la vie et les droits de l'Homme," 1989, s. 10 at 58 [unpublished]; see also appendix A, *infra* at 183. In the event of death, divorce or separation, the gametes would be destroyed.

665. The alternatives as to the fate of the embryos would obviously be limited by the possible use that can be made of them by the person with control in a given situation (expiry of the time limit on freezing, divorce, etc.); see *infra*, rec. 5(3).

Needless to say, leaving the question of control of the embryo to the rules of property law is entirely unethical,[666] but it also seems somewhat premature to suggest that legislatures create a new legal category for these potential living beings. Lawmakers must, however, develop special legal rules that will protect embryos but also permit the ethical debate to continue.[667] Such rules could be developed on the basis of the written, signed consent of the producers given before the embryos are conceived.[668]

While a written statement of consent before embryos are created allows the persons with control to set their terms for the creation of embryos, it is important that they be allowed to change their decision regarding the ultimate fate of the embryos before the embryos are used for the purpose for which they were intended.[669] Of course, in cases where control is shared by a couple, any change would require the consent of both partners.

RECOMMENDATION

5. (1) Before conceiving embryos for future personal use, the person or persons with control should be required to make a written statement of intentions as to the fate of the embryos in such circumstances as the death of a person with control, abandonment of the parental project, expiry of the time limit on freezing, or a divorce or other dispute between the persons with control. A person with control should be able to change, in writing, his or her stated intentions regarding the fate of the embryos as long as the embryos have not been used for their intended purpose; in cases where control over the embryos is shared by two people, both must agree to any changes.

But who should have control? In principle, control over an embryo should be based on both the genetic contribution and the intention of the parties, but what happens when these conflict?

When the embryos are the genetic product of a couple, the partners' interests are equal and also outweigh the potential interest of the bank or clinic that has the embryos in its possession. Thus, the embryos that resulted from the union of the couple's gametes should be jointly controlled by the couple, who alone should have the authority to decide the fate of surplus and frozen embryos. Implantation of any embryos should therefore first be agreed to by the couple. Consequently, the clinic or bank would have no right to keep the embryos or to go against the wishes of the couple in any way. Its only rights would be those expressly granted.

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666. The Commission has written that the law must never treat embryos or fetuses as mere objects. *Biomedical Experimentation Involving Human Subjects*, *supra*, note 7 at 49.

667. Regarding the important question of the status of the embryo, see Keating, *supra*, note 616.

668. See Shuster, *supra*, note 623 at 977. See also John A. Robertson, "Prior Agreements for Disposition of Frozen Embryos" (1990) 51 Ohio St. L.J. 407.

669. See *supra* at 52.

In cases where the embryos are partly the product of a donation from a third person, while it is clear that the donor cannot claim to have rights over the embryos,[670] there are questions regarding the status of the partner who has no genetic link to the embryos. While the wishes of each party have to be considered, the genetic link must give the partner whose gametes were used a greater interest than the other partner. In the event of a dispute over the fate of the embryos, the wishes of the genetically linked partner must prevail.

In cases where the embryos were conceived using donated sperm and eggs (that is, where embryos are not genetically linked to the future parents), control must rest with the bank or clinic that has the embryos in its possession.

RECOMMENDATION

5. (2) Control over embryos conceived using gametes from a couple should be exercised jointly by the partners. Control over embryos conceived using gametes from only one of the partners and a donor should vest in the partner genetically linked to the embryos. Control over embryos conceived with donated gametes should vest in the bank or clinic that has the embryos in its possession.

What is the scope of the control over embryos? What choices can the parties make in terms of disposing of the embryos? Is there a greater interest that would warrant imposing limits on the decisions a couple may make with regard to the disposition of embryos? The Commission has already expressed its opinion of the best way to dispose of surplus embryos; it would prefer that, rather than be destroyed, they be donated for implantation or, failing that, for experimentation. No solution is perfect: the response to those who in the name of a "parental plan" oppose donation could be that destruction is perhaps equally unacceptable. But what then?

It would be appropriate at this point to reaffirm the position we have taken: the person or persons with control may donate the embryos for implantation, donate them to science to be used within the stated limits, or have them destroyed.[671] Otherwise stated, the options for using embryos available to those who have control over them should be limited to implantation, experimentation and destruction.[672]

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670. We will later discuss the rights of donors over their gametes.

671. *Biomedical Experimentation Involving Human Subjects*, *supra*, note 7 at 52; Robertson, *supra*, note 216 at 10: "The consensus emerging from the Ethics Advisory Board, the Warnock Committee, the American Fertility Society, and most other ethics commissions throughout the world that have studied the matter is that special respect for embryos does not require treating them as actual persons or prohibiting couples from opposing transfer." See also Robertson, *ibid.* at 10 n. 15.

672. See also Shuster, *supra*, note 623 at 977.

RECOMMENDATION

5. (3) The possible uses of embryos should be limited to implantation, experimentation and destruction; however, implantation should be prohibited beyond the time limit on freezing.

If the person with control decides to donate his or her embryos, it is important that he or she also state in writing the conditions he or she wishes to attach to the donation, that is, any conditions as to how the embryos may be used.[673] It is also important that the person be able to change the conditions or withdraw consent at any time before the embryos are used.[674]

RECOMMENDATION

5. (4) The person with control over an embryo who decides to donate the embryo should be required, before the donation is made, to make a written statement expressing his or her consent to the donation, and stating the conditions attached to the donation respecting the utilization of the embryo. That person should also be able to change those conditions or withdraw consent by making a written statement to that effect at any time before the donated embryo is used; in cases where control over the embryo is shared by two partners, both must agree to any change.

2. Gametes

Should we treat gametes differently than mere material property? This is a question that must be broached in the context of a broader consideration of the legal regime to be applied to the human body and its parts and substances.[675] The ultimate procreative purpose of genetic material further underlines the need for such a study. It goes without

673. See *supra* at 50-51.

674. See *supra* at 50-51. The possible conditions will be limited by the allowable use of the embryos by the persons with control; see *supra*, rec. 5(3).

675. Hermitte, *supra*, note 207 at 325. Hermitte suggests that the human body and parts and substances thereof fall into the category of "things of human origin intended for human use," between persons and things. Galloux, *supra*, note 619 at 3-4, 31, on the other hand, rules out the possibility of creating a category other than the categories of persons and things:

saying that gametes cannot be considered persons, yet designating them as things would be to ignore their specific nature.

As noted earlier,[676] the specific biological nature of spermatozoa and ova led the Commission to state that gametes and embryos cannot be considered simple cells or simple tissues.[677] Gametes are virtual sources of new human life and must be treated in a manner similar to embryos.

Control over gametes could be covered by private law but without being subject to the system of law reserved for things, and could also be governed by the intentions of the producer. A written statement of intent would assure persons depositing their gametes for storage that their right of control would be recognized and would make it possible to indicate the measures to be taken when, for example, the storage period expired or the persons no longer wished to use the stored gametes. Such consent would also allow persons donating their gametes to set conditions for using the gametes and to withdraw their consent before the gametes are used.

[TRANSLATION]
The division of the legal world into two distinct categories, things and persons, is a fact of life; without it, the law could not be. This *summa divisio* of the law has two corollaries: the categories of legal reality are specific and exclusive. They are specific in that they denote beings of a particular essence or nature, and they are contradictory: a being cannot be thing and person at the same time; it is impossible to shift from one category to the other unless the essence of the being is deprived of all permanence, and this the law does not allow. They are exclusive in that the law affords no room for a third category: this is simply the traditional application of the principle of the excluded middle accepted in our system of law. ...

Genetic material, whether of animal, vegetable or human origin, and whether it is seen from a material or an informational perspective, is a thing. This view makes analysis of the legal problems created by genetics consistent with both scientific knowledge and our system of law based on specific categories. It confirms the fundamentally metabiological and unconventional nature of the person. Attributing personal qualities to human genetic material is tantamount to rupturing the fundamental unity of the living being and to giving persons and things circumstantial definitions the criterion for which would be embodiment. This somewhat irrational approach creates the risk of arbitrariness in law. It ultimately exposes the person to biological reductionism, the inevitable consequence of denying his or her metaphysical dimension.

Real qualification does not involve any devaluation of the living being. Nor does it imply appropriation or commerce: the fundamental categories of things communally owned and things that are not objects of commerce remind us of this. It does not deny the value of genetic material and the human body. Rather, it confirms the notion that value lies not in the nature of the thing, but in the intimacy and necessity of the bond between the thing and the person. It is therefore in terms of the legal regime of these "genetic things" that the law must promote the defence of the living being and the protection of the dignity of humankind.

Galloux does, however, use the notions of extracommerciality and attribution in order to limit legal commerce (legal action the purpose of which is to create, modify or extinguish rights) in products of the human body. See Galloux, *supra*, note 208.

676. See *supra* at 122-23.

677. *Biomedical Experimentation Involving Human Subjects*, *supra*, note 7 at 53.

RECOMMENDATION

6. (1) Control over gametes should vest in the producer.

(2) A person depositing his or her gametes for future personal use should be required, before the deposit, to make a written statement expressing his or her intentions as to the fate of the gametes in such circumstances as the death of the person with control, abandonment of the parental project or expiry of the time limit on freezing. The depositor should be able to change, in writing, his or her stated intentions regarding the fate of the gametes before any embryos are created or the gametes are used for their intended purpose.

Where a producer donates his or her gametes, it is important that he or she state in writing the conditions he or she wishes to attach to the donation, that is, any instructions as to how the gametes may be used.[678] It is also important that the person be able to change the conditions or withdraw his or her consent.[679]

RECOMMENDATION

6. (3) A person who donates his or her gametes should be required, before the donation is made, to make a written statement expressing his or her consent to the donation and stating the conditions attached to his or her donation respecting the use of the gametes. The donor should be able to change these conditions or withdraw his or her consent by making a written statement to that effect at any time before embryos are created or the donated gametes are used.

(4) Possible uses of gametes should be limited to fertilization, experimentation and destruction; fertilization should be prohibited beyond the time limit on freezing.

3. Post-Mortem Use of Gametes and Embryos

Should we limit the possibility of using gametes and embryos following the death of the producers or one of the partners? Should we prohibit their use by the surviving partner? Should the definition of the family be extended to include post-mortem procreation? This raises the whole question of limits on individual freedoms and the force of contracts.

The answers to these questions may depend on the policies adopted regarding access to medically assisted procreation. Opting to protect the two-parent family would mean imposing a limit on freedom of contract. However, if no policy is adopted in an effort

678. See *supra* at 50-51. The options regarding the fate of gametes will of course be limited by the way the persons with control can use them; see *supra*, rec. 6(4). With respect to the time limit on freezing, see *infra*, rec. 12(2).

679. See *supra* at 50-51.

to protect the two-parent family, do we necessarily have to allow restitution to the surviving partner? Some will argue that the psychological problems such a situation may create, both for the surviving partner and for the child, cast doubt on the appropriateness of giving precedence to freedom of contract, and that caution would appear to be in order. For this reason, and given the very nature of the parental plan, it may be concluded that control over gametes and embryos in the event of the death of a producer should be limited to the following options: non-directed donation, experimentation or destruction.[680]

On the other hand, it may be objected that the phenomenon is still so new that it is difficult to raise any cogent arguments to justify restricting freedom in this regard. The Commission holds the view that the restitution of gametes or embryos to the surviving partner after the death of a producer should not be prohibited. Provisions dealing with parentage and succession in cases of post-mortem use will therefore have to be introduced.[681]

The Commission is aware that the solutions proposed in its recommendations on the control over gametes and embryos call for the exercise of provincial jurisdiction. Nevertheless, we felt it was desirable to state our position, as we believe it is essential to standardize the rules of law that will be needed to resolve these conflicts.

E. Parentage

1. Donation of Gametes and Embryos

The parentage of children born as a result of medically assisted procreation raises the issue of the possible application by the courts of existing legislation and principles of law. We have already seen that the current rules of legal parentage are inadequate in some new situations created by medically assisted procreation, and it is difficult to anticipate how they would apply in cases of dispute.[682]

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680. For example, the Council of Europe (*supra*, note 606 at 37) does not permit post-mortem use of gametes, citing the welfare of the child and the risk of break-up of the family unit. The Barreau du Québec (*supra*, note 3 at 24ff.) also recommends prohibiting such use because it deliberately creates an orphan and may cause serious psychological damage if the circumstances are disclosed. France prohibits post mortem use in the interest of preserving the two-parent family. See appendix A, *infra* at 186, in particular note 135.

681. In England, for instance, the post-mortem use of gametes by the surviving partner is neither prohibited nor encouraged. When they consent to the storage of their gametes and embryos, the couple is required to make provision for disposition in the event of death. If there are no specific instructions to this effect, the embryos will not be kept. Before implantation, the surviving partner must receive counselling. Australia holds the view that post-mortem use should be neither regulated nor prohibited. Spain permits post-mortem use if insemination takes place no later than six months after the death. The child is deemed the father's descendant only if he or she is recognized by the father in his will or in some other notarized document; otherwise there is no legal connection with the deceased. For the proposals of other countries and more details, see appendix A, *infra* at 186. Regarding the provisions on parentage and the law of successions, see *infra* at 187ff.

682. See *supra* at 56ff.

The main problems we identified as being associated with the donation of gametes and embryos included: the attribution of responsibilities arising from the paternity of a donor who has no wish to become a father; disavowal of a child whose conception was desired; the possibility of paternity challenges by third parties or a producer and a claim of paternity by the latter; the legal status of the child; and the division of maternity into gestational maternity and genetic maternity.[683] These problems lead us to consider the relative importance to be attached to the future parents' expressed intentions and to the biological and social criteria for paternity and maternity. However, the diversity of the rules governing parentage in Canada[684] shows that even in the area of natural procreation there is no clear answer. This makes the complexity of the problem even more evident and underscores the difficulty of finding a solution in the area of medically assisted procreation. Despite these difficulties, however, the Commission believes that some problems can no longer be eluded. Where donated gametes or embryos are used, parentage should reflect the intentions expressed by the parties at the time of the donation, namely the donor's wish to have no legal connection to the child,[685] and the desire of the couple or recipient to assume responsibility for the child.[686]

Parentage law must therefore provide: (1) the circumstances in which a presumption of paternity may be challenged; (2) that no bond of filiation can be established between a donor and the child; and (3) that any child born as a result of medically assisted procreation is deemed to be a legitimate child.[687]

RECOMMENDATION

7. (1) Provincial parentage laws should reflect the intentions of couples who use medically assisted procreation; accordingly, actions to disavow paternity by a father who gave his consent or to challenge paternity by a third party on the grounds that a donation from a third person was used should not be allowed.

(2) It should not be possible to establish a bond of parentage between a donor and the child.

(3) Legislation that still makes a distinction between legitimate and illegitimate children should recognize children born as a result of medically assisted procreation as having the status of legitimate children.

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683. We will see that this problem is of special significance in the area of surrogate motherhood; see *infra* at 148.

684. See *supra* at 57-58.

685. The Uniform Law Conference has reaffirmed that a sperm donor is not the father of a child born as a result of his donation and has no right or obligation to the child; see *An Act to amend the Uniform Child Status Act*, *supra*, note 199, s. 11.4(2); see *supra*, note 278.

686. *Ibid.*, s. 11.2.

687. *Ibid.*, ss 11.2 and 11.4.

Finally, since we propose that post-mortem fertilization with the gametes of a deceased partner not be prohibited, it is essential that new provisions dealing with inheritance rights be introduced. The Commission believes that children born as a result of assisted procreation should not inherit unless there is a specific reference to that effect in the will.[688]

RECOMMENDATION

8. Provincial succession laws should be harmonized to establish that children born as a result of the post-mortem use of gametes or embryos may not inherit unless there is a specific reference to that effect in the will of the deceased producer.

2. Surrogacy

Although surrogacy contracts are in all likelihood absolutely null and void under Canadian law as it stands at present,[689] the parentage of a child born under such a contract may be subject to contestation. The effect of the rule whereby the woman who gives birth is the legal mother is clear in cases where the surrogate is genetically linked to the child. She is both the genetic and the gestational mother. The social mother can rely only on her intent to become a parent. If the surrogate decides to keep the child, the dispute then becomes a question of custody and is settled by the courts in light of the interest of the child in the particular case.

However, the use of surrogates raises a new issue in law, namely the right of the social mother who is also genetically linked to the child to claim and prove her legal maternity, just as the genetic father could claim and prove paternity.[690] The interest in promoting sound application of the principles and rules of existing law thus comes up against the conflict between the interests of the gestational mother, the genetic mother and the child. The interest of the child in having clear parentage and a stable and loving family environment is not open to question. When maternity is divided among the genetic, gestational and social mothers, it is difficult to rule in favour of one or the other. Clearly, the link that is formed between the surrogate and the child during gestation is important and can hardly be compared to the link that may be established with the surrogate's husband during the pregnancy. It is therefore easier for the biological father to oppose his interest to that of the surrogate's husband than for the genetic mother to challenge the surrogate's interest. Yet we cannot ignore the interest of the genetic mother who attaches to her "donation" an expression of her intent to become a mother. Further, assessing the interest

688. For a similar view, see White Paper, *supra*, note 654, para. 60 at 10. For a general discussion, see appendix A, *infra* at 186.

689. See *supra* at 65-67.

690. It should be noted that this is not a right arising from the contract, since the contract is in all likelihood absolutely null and void, but rather a question of legal parentage.

of the child in having as a mother his or her gestational or genetic mother becomes an arbitrary exercise because we do not have the knowledge to make such a decision. Making such a choice now, even in the name of the child's stability, may be damaging in the long run.

We recognize the shortcomings of current law and the general interest in anticipating and resolving questions of parentage and the interest of the child in this context. However, we feel that it would be hasty to adopt just any rule to solve the problem of stability by choosing between gestational and genetic maternity.[691] Since experience and the existing rules are based on a different reality, namely the uniqueness and indivisibility of maternity, we cannot simply extend them to medically assisted procreation without more insight. We believe the fairest solution would be to let this new phenomenon unfold in the courts and in society before a rule is imposed.[692] At this stage, the interest of the child would be better protected by a court assessment of each case. The status quo leaves the door open to the judicial discretion that may be essential to the resolution of such disputes.

For these reasons, the rule whereby the woman who gives birth is necessarily the legal mother of the child should not, as it relates to surrogate motherhood, be entrenched in legislation.

II. Medically Assisted Procreation and Safety

Based on the preceding chapters, we can conclude that medically assisted procreation raises serious questions of safety for the people using the technologies and for the resulting children. Examples include problems related to low success rates; significant variation in the way such rates are calculated and interpreted; the physical and psychological risks; the lack of standards in record keeping; and the lack of national data.

A. Success Rates: The Importance of Informed Consent

The confusion surrounding the success rates of certain technologies leads us to question whether infertile couples are in a position to choose the option that is best for them.[693] Indeed, the different methods of reporting success rates[694] make interpretation very difficult, and yet an understanding of the rates is essential to informed consent.[695]

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691. See, however, *An Act to amend the Uniform Child Status Act*, *supra*, note 199; see also *supra*, note 325.

692. See *Anna J.* v. *Mark C.*, *supra*, note 324. Ms. Johnson was the first surrogate mother to claim parental rights to and custody of a child to which she was not genetically linked.

693. See *supra* at 5 and 13-15.

694. *Ibid.* Louise Vandelac, "La face cachée de la procréation artificielle" (1989) 213 La Recherche 1112 at 1114: [TRANSLATION] "Whereas in the public's mind the success rate of IVF and GIFT measures probability for each attempt to have a child, biomedical teams tend to view it simply as their own rate of success in certain phases of the process.

There are as many success rates are there are methods of calculation."

695. See *supra* at 62-63 regarding the need for free and informed consent.

In addition, the available success rates for artificial insemination are based on studies that for the most part were done when fresh sperm was being used.[696] These rates are therefore no longer conclusive because more recent studies have shown that the freezing of sperm, which is necessary today primarily to prevent the transmission of AIDS, reduces motility, longevity and ability to fertilize by half.[697] New studies should therefore be conducted to provide infertile couples with more realistic success rates.

In chapter 1, we demonstrated the complexity and lack of consistency in the way results are reported in the area of IVF and GIFT. Since success rates vary depending on the numerator and denominator chosen, it is not surprising to learn that the reported rates create confusion and do not make for easy comparison.

Given the very low success rates of IVF[698] and the vulnerability of infertile couples (for whom medically assisted procreation is often the last chance to conceive a child), it is essential that couples who choose this technology — as well as related procedures and GIFT — give free and informed consent. For this reason, clinics should be required to report actual results in a uniform manner, so that reliable statistics are readily accessible.[699]

To make possible a complete assessment of these results, it is therefore important that the content of clinical reports be standardized.[700] The statistics should show not only the number of pregnancies achieved or children born, but also the number of ectopic pregnancies, the number of spontaneous abortions, the number of embryos implanted, the rate of multiple pregnancy, the rate of birth defects and other possible problems.[701]

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696. See *supra* at 27.

697. *Ibid.*

698. See *supra* at 15-17.

699. We view this as a measured reaction compared with the proceedings recently taken by U.S. authorities against clinics that allegedly promoted their success rates unfairly and fraudulently. See Proposed Consent Agreement with Analysis to Aid Public Comment, *supra*, note 562; *Federal Trade Commission* v. *Jacobson*, *supra*, note 562. Compare *R.* v. *Gregory*, *supra*, note 561.

700. See *supra* at 15.

701. See *supra* at 17ff. On the subject of success rates and the need for national controls, Vandelac, *supra*, note 694 at 1116, writes as follows:

> [TRANSLATION]
> It is surprising that the notion of success rates is not homogeneously redefined in terms of the number of children conceived through IVF and healthy at the age of one month compared to the total number of superovulations. This would reduce the impact of multiple transfers in success rates and would lead to reconsideration of multiple transfers and IVF itself.
>
> Some reports, such as those by Australia, Wagner and the OMS, and the recent opinion by the Conseil du statut de la femme in Quebec tend to share this view and call for tighter regulation of artificial fertilization, as well as a redefinition of and greater transparency in statistics. However, public officials seem slow to react.

From another standpoint, analysing such data on a national basis would provide insight into the problems medically assisted procreation creates for our society and the people involved. The lack of uniformity in the methods used to report success rates and the general dearth of statistics are obstacles to proper evaluation of the current situation. We should require not only that the results obtained by clinics be reported uniformly, but also that the data be centralized and analysed on a national level. The standardization and centralization of data describing clinical activities and analysis of those data are essential because they make it possible to monitor practices. This could be done by establishing a national registry.

A confidential and voluntary national registry has already been set up by one group of health professionals. However, the very fact that the registry is voluntary creates major problems that make it virtually useless.[702]

To ensure that clinical reports are available, that the data are centralized, analysed and used to produce reliable statistical reports, and that the statistics can be accessed, clinics should be required to submit annual reports to a central registry managed by an administrative agency that we will discuss later. As stated earlier, these reports should include data on the use of all medically assisted procreation technologies, and a standard reporting method should be used; minimum content should be set and the presentation of data fixed. Statistical reports produced using the clinical reports should be available to the public.

RECOMMENDATION

9. Clinics offering medically assisted procreation services should be required to submit written annual reports to a central registry; the minimum content of the reports should be set and the data should be presented in a prescribed form.

B. Risks

1. Physical Risks

The main risks associated with the use of gametes from a third person are the transmission of infectious or genetic diseases and consanguinity if the sperm of a particular donor is used too often.[703]

The risk of transmitting genetic and infectious diseases is greatly reduced if the donor is properly assessed and the gametes used are properly screened.[704] It is therefore important not only that standards for screening and selection be introduced, but also that they be applied consistently.

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702. See *supra* at 16-17.

703. See *supra*, note 163; see also *supra*, note 181.

704. See *supra* at 5, 26-27 and 32-33.

Unlike blood donations,[705] gamete and embryo donations are not currently subject to any national regulations,[706] yet the need for national standards was noted in one of the first Canadian reports on medically assisted procreation.[707] Further, a 1981 report to the Minister of National Health and Welfare on the storage and use of human sperm recommended that "[f]ederal regulations governing standards for the acquisition, preservation and importation of human sperm be established."[708] No legislative action was taken, however. All that has happened since is that a number of organizations have adopted guidelines.[709]

The uncertainty surrounding the application of uniform selection, screening and storage criteria makes it difficult to ensure the essential quality[710] of the gametes and embryos used in medically assisted procreation. Donor selection, screening of donations and storage conditions are important factors in the safety of both mothers and their children alike, as neither are able to protect themselves against these risks.[711]

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705. The *Food and Drugs Act*, *supra*, note 298, and its regulations set standards for, *inter alia*, advertising, labelling, sale, import, handling, storage and the number of donations permitted. The Canadian Red Cross Society also has standards in some of these areas. See *Procurement and Transfer of Human Tissues and Organs*, *supra*, note 250.

706. See *supra* at 64.

707. British Columbia Royal Commission on Family and Children's Law, *supra*, note 470 at 33:

> As an overall protection for all concerned, it is felt that the Health Protection Branch, Canada National Health and Welfare, should be responsible for the *establishment of standards* and for the surveillance of the safety of the whole operation of sperm collection, processing, storage, packaging and dispensing, just as they would for a pharmaceutical product.
>
> Because seminal fluid does not fall within the categories of foods, drugs, or devices which have been legislated as the mandate of the Health Protection Branch, a new legislation at the federal level would be required before such responsibilities can be vested within that agency [emphasis added].

Further, the final recommendation in the report reads:

> The Health Protection Branch, Health and Welfare, Canada, should be requested to take on responsibility for surveillance of human sperm banking, with associated collection, processing, distribution and documentation services. Appropriate *federal legislation* to provide this mandate should be proposed [emphasis added].

708. *Report on Human Sperm 1981*, *supra*, note 148 at xii.

709. See, *e.g.*, the Canadian Fertility and Andrology Society, *supra*, note 11. The Society's guidelines cover such matters as donor selection and genetic screening. However, see *supra*, note 300, and accompanying text. We stated *supra* at 32, that even though the merits of screening for infectious and genetic diseases have been widely discussed and advocated around the world, there is still concern that some clinics may choose not to follow such guidelines, as they have no legal force; see also *supra* at 64. Rona Achilles, "Donor Insemination: The Future of a Public Secret" in Overall, ed., *supra*, note 129, 105 at 111 writes as follows:

> The importance of screening sperm donors became particularly apparent with the advent of acquired immunodeficiency syndrome (AIDS). Several guidelines for screening of donors have been issued by medical associations. However, my own exploratory study, as well as a broader survey of U.S. physicians, indicated that most physicians did not follow the guidelines — only forty-four percent report testing for human immunodeficiency virus (HIV) antibodies.

The author refers to her own previous work, *The Social Meanings of Biological Ties: A Study of Participants in Artificial Insemination by Donor*, Doctoral Thesis, University of Toronto, 1986; Curie-Cohen, Luttrell and Shapiro, *supra*, note 282 at 585-90; and *Artificial Insemination: Practice in the United States*, *supra*, note 181 at 37.

710. The word "quality" is used in terms of safety, not eugenics.

711. Of course the various professional bodies and associations will have to be involved in developing these standards in the public interest.

RECOMMENDATION

10. Uniform and mandatory standards for the selection, screening and storage of gametes and embryos, and the selection and screening of donors, should be developed at the national level.

Since the use of fresh semen entails a considerable risk of transmitting diseases such as AIDS and screening must take into account the latency period of these diseases, it is important that donated sperm be frozen and that donors be properly screened.[712] The down side of such a policy is clear: clinics and banks have to wait some time before they can use donated sperm and are forced to repeat the required tests after each sperm donation. Further, such a policy completely rules out the possibility of using fresh semen for IVF, GIFT and AID, thereby reducing the success rate of these procedures. Despite these disadvantages, the Commission believes that clinics that use donated sperm in AI, IVF and GIFT must be required to use frozen sperm, and that clinics and banks that recruit donors must be required to test donors for the screening of the above-mentioned diseases.[713] These requirements are similar to those currently applied to blood donation.

RECOMMENDATION

11. Donated sperm should be frozen and should not be used for fertilization until the donor has been properly tested for evidence of the AIDS virus.

Freezing gametes and embryos creates certain problems, however. Science still does not know a great deal about the impact of prolonged cryopreservation, and the principle of generations may be completely altered because an embryo could in theory be reimplanted after a very lengthy period of freezing. These problems have led some countries to limit the length of time embryos and gametes may be frozen.[714]

The Commission recognizes that these limits are completely arbitrary[715] given the current level of expertise, but believes it is important from a safety and sociological standpoint to put a time limit on freezing. In setting the maximum freezing time, however, it is important to consider the fact that too strict a limit (for example, one that would allow embryos to be frozen for only a very brief period) would force women to deal with the risk and inconvenience of more frequent superovulation and egg retrieval or else the risk of having a larger number of embryos implanted per cycle. For the moment, the

712. See *supra* at 26-27 and 32-33.

713. See appendix A, *infra* at 191-92.

714. See appendix A, *infra*, table 3 at 207-209.

715. *Biomedical Experimentation Involving Human Subjects*, *supra*, note 7 at 53.

Commission reaffirms the five-year limit recommended in its working paper on experimentation.[716] However, the Commission would like to see more extensive research carried out nationally on time limits and, more specifically, on the effects of cryopreservation. The task of conducting the study could be given to a central agency which we will discuss later.

RECOMMENDATION

12. (1) Embryos should not be frozen for more than five years. Further, the federal government should encourage research on the effects of cryopreservation in order to reassess this five-year limit.

Unlike embryos, gametes can be frozen even before a couple makes plans to have a child, because the reason for freezing may be the prospect of infertility in a person about to undergo medical treatment or surgery.[717] In light of this fact, we believe a limit of ten years is more appropriate.[718] The earlier comments regarding the need for more extensive research on the effects of cryopreservation apply here as well.

RECOMMENDATION

12. (2) Gametes should not be frozen for more than ten years. Further, the federal government should encourage research on the effects of cryopreservation in order to reassess this ten-year limit.

To minimize the risk of consanguinity, it is also important that a limit be placed on the number of times gametes from the same donor may be used.[719]

However, since the risk depends on such factors as the density and mobility of the population served by the bank or clinic, it is important that the limit be flexible enough to take these factors into account. Studies will have to be conducted in this area.

RECOMMENDATION

13. A limit should be placed on the number of times gametes from the same donor may be used. Further, the studies needed to set an appropriate limit should be encouraged.

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716. *Ibid.* See also Act 35/1988, of November 22, on Techniques of Assisted Reproduction, s. 11 (Spain); Conseil d'État, *supra*, note 664; *Human Fertilisation and Embryology Act 1990*, *supra*, note 421, s. 14; White Paper, *supra*, note 654 at 9; Canadian Bar Association, *supra*, note 278 at 33-37. For more details, see appendix A, *infra* at 191-92 and table 3 at 207-209.

717. See *supra* at 27.

718. See *Human Fertilisation and Embryology Act 1990*, *supra*, note 421, ss 4, 14; White Paper, *supra*, note 654 at 9.

719. See *supra* at 28. In comparative law, see appendix A, *infra* at 192-93.

Finally, we have already indicated that some clinics import gametes from the United States.[720] The existence of international traffic in these products raises the question of whether the standards applied in other countries are sufficient. It is therefore essential to ensure that imported gametes and embryos also meet our national standards.[721]

RECOMMENDATION

14. The import of gametes and embryos should be restricted to certified banks. Imported gametes and embryos should have to meet Canadian standards.

IVF and GIFT entail additional risks of their own, most of them resulting from superovulation and multiple pregnancies.[722] The rate of multiple pregnancy is of particular interest here because it raises the question of the appropriateness of limiting the number of embryos implanted or eggs fertilized per treatment cycle. We showed at the beginning of our study that transferring more than one embryo increases the chances of conceiving but also increases the possibility of multiple pregnancy. Given the high risks associated with multiple pregnancies,[723] a limit on the number of embryos implanted per cycle would seem to be in order.[724] It is not clear, however, that such a limit would help reduce the rate of multiple pregnancy. It should be remembered that the number of embryos transferred is not the only factor affecting the chances of conception and the chances of multiple pregnancy. We have already seen that transferring three embryos may in fact result in a higher rate of multiple pregnancy than transferring four.[725] It is therefore essential that greater importance be attached to the specific circumstances of each case (age of the woman, previous pregnancies, and so on). An arbitrary limit would not attain the desired goal, namely ensuring the safety of the mother and the unborn children.

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720. See *Report on Human Sperm 1981*, *supra*, note 148 at 13.

721. Some genetic products may fall within the scope of the *Food and Drugs Act*, *supra*, note 298. However, the uncertainty as to whether gametes and embryos are included and the need for specific standards mean that more direct intervention is needed. Regarding this matter and the application of the *Quarantine Act*, *supra*, note 558, s. 5, and the *Customs Tariff*, R.S.C. 1985, (3d Supp.), c. 41, see *Procurement and Transfer of Human Tissues and Organs*, *supra*, note 250. It is, to say the least, surprising that safety is carefully regulated in the area of animal genetic products, but there are no specific provisions dealing with human gametes and embryos. It is interesting to note that Canada last year exported more than 1,200 frozen animal embryos and 2 million doses of animal sperm under a national regulatory system. The system provides for the licensing of some 48 national services that transfer genetic material to be used for reproduction and requires permits to import and export fertilized and unfertilized gametes. Last June, Parliament updated this disease control system in the *Health of Animals Act* (*supra*, note 560). See *Animal Disease and Protection Regulations*, *supra*, note 560, ss 32, 50, 59, 84 and 115, administered by Agriculture Canada under the *Animal Disease and Protection Act*, replaced by the *Health of Animals Act*, *supra*, note 560, ss 2, 14, 16 and 19.

722. It was stated *supra* at 17, that the rates of spontaneous abortion, multiple pregnancy, ectopic pregnancy and Cesarean section are substantially higher than the rates observed in the general population.

723. See *supra* at 17ff.

724. See *supra* at 20. The Interim Licensing Authority in the United Kingdom and the Reproductive Technology Accreditation Committee in Australia have implemented recommendations limiting to three or, in extreme cases, four the number of embryos that may be implanted.

725. See *supra* at 20.

The development of technologies that use the normal cycle of ovulation, thus eliminating the risks associated with the drugs used in superovulation and reducing the risk of multiple pregnancy, is certainly to be encouraged. Pending more conclusive results, the primary focus must be to reduce the rate of multiple pregnancy.

RECOMMENDATION

15. Every effort should be made to reduce the risk of multiple pregnancy and to promote the development of technologies that follow the normal cycle of ovulation. Accordingly, the federal government should encourage studies and research aimed at reducing the multiple-pregnancy rate and developing technologies that follow the normal cycle of ovulation. Further, clinics should be required to document and justify the number of embryos implanted in each treatment cycle.

2. Psychological Risks

False hopes based on unrepresentative success rates, the consequences of high failure rates with some technologies, the psychological impact of the various stages in IVF and GIFT procedures, and genetic intervention by a third person represent significant psychological risks for people who decide to resort to medically assisted procreation.

Behind the low success rates lie the pain and anguish of couples for whom the process has failed.[726] Other sources of stress and anxiety are the high cost of some treatments, the physical demands placed on the person being treated and the different steps they entail.[727]

Finally, using a donation from a third person to form a family unit can also create psychological risks for the future parents and the child. The psychological stress of keeping such a secret, the consequences of unprepared disclosure, the possible frustration of the

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726. On the subject of success rates, Vandelac (*supra*, note 694 at 1115) writes: [TRANSLATION] "The success rate masks ... the pain and anguish of those who have suffered miscarriages, ectopic pregnancies or stillbirths and had to deal with the accompanying risks, pain, dashed hopes, complications and hospitalization." Carolyn M. Mazure and Dorothy A. Greenfeld, "Psychological Studies of In Vitro Fertilization/Embryo Transfer Participants" (1989) 6:4 J. In Vitro Fert. Embryo Transfer 242 at 248: "The other most common emotional experience appears to be that of a grief reaction when treatment does not yield a pregnancy." See also *ibid.* at 250 on the same subject. Regarding the attitude and feelings generated by infertility, see *ibid.* at 243-44:

> Freeman *et al.* reported that in their pretreatment interviews of 200 IVF/ET couples, 49% of the women and 15% of the men considered infertility the most upsetting experience in their lives as compared with other serious losses such as death or interpersonal stressors such as divorce. Mahlstedt *et al.* asked IVF/ET participants to return questionnaires by mail at the end of a treatment cycle or when pregnancy status was known. In this study, participants were also asked to compare stress from infertility, death, and divorce. Of those who had experienced divorce or death of a close friend or family member, ... 63% reported that infertility was as stressful or more stressful than divorce, and 58% reported infertility as stressful or more so than death of a loved one.

727. Mazure and Greenfeld, *supra*, note 726 at 248-49.

father with regard to the child and the mother (if she has a biological link with the child) and the identity problems the child may experience cannot be ignored. The need for support therefore goes beyond medical assistance in conceiving a child. Because people diagnosed as infertile (often after years of failure and investigation of the problem) are fragile and face difficult choices, they must be very well informed about what lies ahead for them. In order to be able to make a free and informed decision, it is important that the infertile couple be given the option of consulting experts (psychologists, physicians and others) at any time during and after medically assisted procreation technologies are used, regarding all of the risks, physical[728] and psychological, as well as the actual success rates. Clinics that offer medically assisted procreation services should therefore be required to provide counselling services.[729] We will come back to this question in our discussion of the certification of clinics.

RECOMMENDATION

16. Every clinic offering medically assisted procreation services should be required to provide to persons using medically assisted procreation, either before, during or after the application of a technology, counselling services whereby these persons could obtain from experts (psychologists, physicians and so on) the assistance and information they might need concerning the specific problems involved in medically assisted procreation.

C. Record Keeping

Proper medical records are not only essential in terms of regulation,[730] the compiling of statistics and the carrying out of studies on the long-term effects of various technologies, but may also prove extremely important in terms of the physical and psychological health of the child. Medical information about a child's genetic heritage may be needed to give the child optimum medical care. It is therefore essential that this information be kept and that it be accessible.[731]

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728. See *supra* at 17ff.

729. See *supra* at 23. In New South Wales, counselling is mandatory; see appendix A, *infra* at 193. Rec. 19 of the Warnock Report (*supra*, note 421 at 82) reads as follows: "Counselling should be available to all infertile couples and third parties at any stage of the treatment, both as an integral part of NHS [National Health Service] provision and in the private sector." The Ontario Medical Association guidelines (*supra*, note 85 at 28) include a general provision on the need for counselling services: "Special attention should be given to the emotional support and needs of couples and their families. For many couples, IVF is not appropriate treatment for their infertility. Counselling should, therefore, be available for all couples to provide a forum to discuss the alternatives to IVF."

730. Knoppers and Sloss, *supra*, note 269 at 681: "Linkage and tracing through complete and long-term record keeping are necessary to effectively regulate and evaluate the choice of gametes." Such control also makes it possible to trace contaminated gametes and the people who donated and received them.

731. See "The Right to Be Informed of One's Biological Origins," *supra* at 90. At 91 we stated that refusing to disclose information needed to protect life and health would be a violation of the right to security of the person conceived through medically assisted procreation. See also art. 583 of Bill 125, *supra*, note 196.

However, keeping such records and ensuring access to the information they contain raise the question of respect for the privacy of the parties, in particular their right to anonymity. Information about the identity of the parties should therefore be kept separate from the medical records, and clinics should set up a system that would enable physicians to link donors to recipients and thus to the children conceived using their donations. The system would ensure access to the necessary medical and genetic information but would not violate the right of the parties to privacy.[732] In view of this right, only information needed to attain the desired objectives should be collected, and clinics should be responsible for protecting the confidentiality of the information they hold.[733]

Yet identifying information[734] and social information[735] may have a bearing on the psychological well-being of the child. This raises the whole question of the right of the child to know the circumstances of his or her birth and the identity of his or her progenitors.[736] As stated above,[737] this is not an entirely new issue for us. In the area of adoption, some provinces have set up systems to enable adopted children to locate their biological parents.[738] It is recognized that searching for and finding one's biological parents, or at least knowing who they are, fills a major psychological need in children who are adopted, and an analogy can undoubtedly be made with children conceived as a result of a donation.

The interest a child may have in knowing the circumstances of his or her birth is, on the one hand, at odds with respect for the parents' privacy. Forcing the parents to disclose to the child information about his or her origins could be perceived as an unconstitutional infringement of the fundamental right of the parents to make the decisions that they feel are appropriate in the course of raising their children. Further, it is very difficult to determine the child's interest objectively. As the OLRC has noted, "[t]he social and psychological ramifications of disclosure are simply not clear; one cannot accurately predict the

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732. For the various positions held abroad, see appendix A, *infra* at 194ff.

733. A number of provisions to this effect are included in *An Act to amend the Uniform Child Status Act*, *supra*, note 199. These provisions make physicians responsible for keeping records, but access to records which may be related is made possible by a central registry. Responsibility for protecting the confidentiality of this information rests with the agency that receives it.

734. Identifying information has to be kept in any case because it is essential in terms of donor liability.

735. This may include information about the ethnic origin, profession, education, religious affiliation and interests of the parties involved. See, *e.g.*, Ministry of Community and Social Services, *Adoption Disclosure Services* (Toronto: The Ministry, 1987) at 5.

736. Lori B. Andrews, "Legal and Ethical Aspects of New Reproductive Technologies" (1986) 29:1 Clin. Obstet. Gynecol 190 at 198: "Some individuals who were conceived through artificial insemination and are now in their 20s and 30s feel that they have suffered emotionally as a result of being created with donor sperm. Like adoptees, some artificial insemination children feel that, for reasons of their psychological and medical well-being, they need to learn about or meet their biological fathers, the sperm donors." To the same effect, see Achilles, *supra*, note 709 at 110.

737. See *supra* at 60-61 and 90ff.

738. See *supra* at 60-61 and note 281.

implications in individual cases."[739] Such decisions must take into account the personality and needs of the particular child and must be left to the discretion of the parents.[740]

On the other hand, the interest of the child is also at odds with the donor's interest in remaining anonymous. This therefore requires a balance to be struck between the donor's right to privacy and the child's right to know about his or her origins.

While identifying information has to be kept (as it is essential to establishing donor liability), it should be disclosed only if the donor consents when the child makes the request.[741]

At the request of the child or the parents, non-identifying social information should, however, be disclosed. Such general information is important to the child's psychological development and in no way infringes the donor's privacy.[742]

RECOMMENDATIONS

17. (1) Clinics should be required to keep records (on the donor, the mother and the child) that allow physicians to link the donor to the recipient while protecting the anonymity of the parties.

(2) Only the information needed to attain the following objectives should be collected: to permit access to medical and genetic information that may be needed to obtain optimum medical care; to meet the psychological needs of the child; to ensure proper clinical reports; and to permit studies on the long-term effects of the various technologies used in medically assisted procreation.

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739. *Supra*, note 2 at 187.

740. Even in Sweden, where the child has the right to know about his or her origins, disclosure is left to the parents.

> The travaux préparatoires of the new legislation begin by affirming the importance of parental frankness and honesty towards the child. Parents ought therefore to tell the child about its origins at the earliest suitable opportunity. It has not been found appropriate to legislate on this point. Instead it is observed that, during the psychosocial counselling procedure which proceeds insemination, the physician should try to make the prospective parents understand the importance of being frank with the child.

Göran Ewerlöf, "Artificial Insemination Legislation and Debate" (1985) 29 Current Sweden 1 at 7.

741. It is interesting to note that in Sweden, while the enactment of a law that recognized the child's right to know about his or her origins initially led to a significant drop in the number of donors, it took only a few months for the situation to correct itself. Achilles, *supra*, note 709 at 105-15: "[W]ithin months the number of donors had risen to previous levels, and reports indicate that a different kind of donor is becoming involved in programs." See also Bertil Wennergren, "Consequences of New Regulations in Reproductive Medicine and Human Embryo Research in Their Relationship with Science, Ethics and Law. The Swedish Approach" in Byk, ed., *supra*, note 640, 387 at 389; and Lena Jonsson, "Artificial Insemination in Sweden" in *Sortir la maternité du laboratoire*, *supra*, note 493, 148 at 154.

742. See *supra* at 90. Most recent reports on adoption and medically assisted procreation have recommended that non-identifying information be made available and that identifying information be disclosed only with the consent of the biological parents. See Knoppers and Sloss, *supra*, note 269 at 693-96.

(3) Clinics should be responsible for protecting the confidentiality of the information they hold.

18. The legal parents or the child should be able to request disclosure of non-identifying information, in particular social information (such as ethnic origin, profession, education, religious affiliation and interests of the donor). However, identifying information should be disclosed only with the donor's consent.

In light of the recent ruling in *R.* v. *Thornton*,[743] we can conclude that where a donor intentionally conceals important information or gives false information, such failure or negligence may be subject to prosecution under the *Criminal Code*, either section 180 (public mischief) or section 219 (criminal negligence).[744] It is therefore essential that donors' names be kept and that donors be prevented from using their right to remain anonymous in order to obtain immunity against criminal prosecution related to a false disclosure or a failure to disclose.[745]

RECOMMENDATION

19. It should be possible to reveal to the prosecuting authorities the identity of any donor who fails to provide information or who provides false information for the purpose of a criminal prosecution related to such false disclosure or failure to disclose.

D. Long-term Evaluation

The uncertainty that prevails regarding the possible risks associated with medically assisted procreation means that vigilance is needed. For example, while the use of frozen gametes and embryos does not appear to pose a threat to safety at present, caution forces us to recommend that studies continue to monitor and examine the long-term effects of cryopreservation on health and safety. Generally, the long-term impact of the technologies on children born as a result of assisted procreation should also be monitored. And if studies on long-term effects are to be carried out, it is essential that records be properly kept and that data be compiled and made available nationally.[746]

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743. *Supra*, note 270.

744. See ss 180, 216 and 219 of the *Criminal Code*. Judge Flanigan in *R.* v. *Thornton* (*supra*, note 270) wrote at 34 of his decision: "Again it is my view that the Code has provided at least three sections that could cover the actions of the accused in this case. These include the sections dealing with criminal negligence, public mischief, and the sections relied upon by the Crown, that is, s. 180 and s. 216."

745. To the same effect, see the *Report on Human Sperm 1981*, *supra*, note 148 at 22. For more details, see appendix A, *infra* at 196.

746. Recs 9 and 17, *supra*, address these concerns.

RECOMMENDATION

20. Studies should be undertaken to determine and measure the long-term effects of medically assisted procreation technologies on the resulting children.

III. Implementing the Recommendations

A. Controlling Practice

Considering the inadequacy of the controls now in place,[747] and in order to effectively address the various aspects of public safety, we feel it is essential to regulate certain aspects of the activities of clinics and banks.[748] A system of certification could impose conditions and restrictions.[749] Obtaining certification would thus be conditional on clinics and banks meeting certain prerequisites (for example, the requirement to set up a counselling service and a filing system[750]), while compliance with other standards,[751] duties,[752] restrictions[753] or prohibitions[754] would be needed to maintain certification. This would make it possible to determine, for example, whether clinics and banks are observing the prohibitions on the selection and commercialization of gametes and embryos.[755] Finally, the system would also make it possible to regulate other aspects of medically assisted procreation, such as the forms used to record the intentions of those with control over gametes and embryos.[756]

RECOMMENDATION

21. (1) A system of certification for clinics and banks should be established in order to regulate the following issues:

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747. See *supra* at 101ff.

748. See "Regulation of Procedures," *supra* at 112. See also the recommendations on standards for the selection, screening and storage of gametes and embryos (rec. 10) and the recommendations that impose requirements (recs 9, 11 and 15 to 19), restrictions (recs 5(4), 6(4) and 12 to 14) or prohibitions (recs 2 and 3) on clinics and banks. The Commission recommended in *Biomedical Experimentation Involving Human Subjects* (*supra*, note 7) that standards governing the creation, expansion and management of sperm and embryo banks should be developed (*ibid.*, rec. 8(3) at 54).

749. Concerning the effects of certification, see, *inter alia*, *supra*, rec. 14.

750. See *supra*, recs 16 and 17.

751. Standards concerning, *e.g.*, selection, screening and storage of gametes and embryos; see *supra*, rec. 10.

752. See *supra*, recs 9, 11 and 15 to 19.

753. See *supra*, recs 5(4), 6(4) and 12 to 14.

754. See *supra*, recs 2 and 3.

755. See *supra*, recs 2 and 3.

756. See *supra*, recs 5 and 6.

(*a*) national standards for the selection, screening and storage of gametes and embryos;

(*b*) the requirement to submit annual reports to a central registry and the content of the reports;

(*c*) the requirement to freeze donated sperm and use it only after the donor has been properly tested for evidence of the AIDS virus;

(*d*) the duty to justify in writing the number of embryos implanted per treatment cycle;

(*e*) the duty to establish counselling services and the composition and duties of such counselling services;

(*f*) the duty to keep medical records and the content of those records;

(*g*) the duty to establish a system that allows the physician to link donors to recipients while protecting the anonymity of the parties;

(*h*) the duties pertaining to access to identifying and non-identifying information;

(*i*) the restrictions pertaining to the allowable use and time limits on the freezing of gametes and embryos, the frequency of use of gametes from the same donor and the import of gametes and embryos;

(*j*) the prohibitions pertaining to the selection and commercialization of gametes and embryos; and

(*k*) the conditions attached to the donation of gametes and embryos, the notion of control over gametes and embryos, the manner in which the person having such control may express his or her intentions and the terms and conditions governing the exercise of such intentions.

We must also ensure that private clinics do not circumvent proposed quality-control requirements by, for example, using fresh semen from their own network of donors, since such action could jeopardize the safety of the mother and the unborn child. Accordingly, it is important to restrict the practice of medically assisted procreation to certified clinics and to introduce sanctions for unauthorized operations.[757] In addition, it is important to

757. We are including artificial insemination here even though it is less invasive and more private in nature, because uncontrolled use of the technology could be harmful to the child. As stated earlier, it is essential that, for example, donors be carefully selected, that sperm undergo proper screening, and that identifying medical, genetic and social information be kept. Such controls would also ensure compliance with the restrictions on the selection of gametes and embryos: see *supra*, rec. 2. See also appendix A, *infra* at 197-98.

ensure that clinics and banks comply with the various prohibitions, restrictions and duties recommended in response to the various problems associated with the use of medically assisted procreation technologies (regarding, for example, the selection, commercialization and use of gametes and embryos).[758]

RECOMMENDATION

21. (2) The application of medically assisted procreation technologies should be restricted to certified clinics, and only certified banks should be permitted to store, preserve and import gametes and embryos.

B. The Need for a National Agency

How can all these recommendations be implemented? Whether they relate to principles, the administration of justice or public safety, the nature and purpose of the proposed recommendations are such that they require centralized, uniform control of medically assisted procreation. To such administrative control must be added the establishment of the certification system, regulatory activities, the monitoring of practices[759] and the establishment of a central registry. It is also essential, on the national level, to encourage the necessary research and studies and to undertake long-term studies.

The need for uniformity, whether in terms of social choices or control of practices or medically assisted procreation in general, and the need to avoid interprovincial "procreative tourism," mean that the federal, provincial and territorial governments must work together to establish national controls.[760]

It is certainly appropriate to co-ordinate and control the use of medically assisted procreation technologies, and it would be easy in a centralized country to create a statutory agency with the necessary powers and duties. In Canada, however, where the jurisdiction needed to exercise such control is shared by the federal government and the provinces, the two levels of government must work with the professionals involved to develop national controls.

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758. Similarly, see appendix A, *infra* at 197-98. This form of control would enhance the controls applied by professional associations that normally protect the public against malpractice or unlawful medical practice and provide ethical benchmarks.

759. This includes monitoring of compliance with regulatory duties, restrictions and prohibitions; see *supra* at 161.

760. Regarding the need for co-operation between the federal and provincial governments, see, *inter alia*, OLRC, *supra*, note 2, recs 9 and 17(2) at 276-77.

Creating a national agency with regulatory powers under both the federal and the provincial governments seems to be the best way of ensuring that our recommendations have the desired effect.[761]

We prefer this approach to the enactment of a general law on medically assisted procreation. Creating a national administrative agency would ensure the flexibility needed in this extremely complex field. Such an agency would provide for systematic intervention and proper control and would make it possible to solve problems that the law is currently unable to solve.

The agency should be a multidisciplinary team of qualified individuals. Its role would be to protect the public; grant certification; regulate certain aspects of the activities of banks and clinics and medically assisted procreation in general (certification criteria, terms and conditions of consent to donation and storage, and so on); ensure compliance with the various duties, standards, restrictions and prohibitions; establish a central registry; identify real problems on the basis of national data; analyse the various success rates and compile statistics; ensure long-term control through studies on the technical, medical and psychological aspects of medically assisted procreation; prevent exploitation and commercialization in the area of medically assisted procreation; promote any research and studies deemed necessary (research to determine the maximum freezing time for gametes and embryos, or aimed at reducing the number of multiple pregnancies or developing technologies that follow the natural cycle of ovulation, and so on); and advising the various governments on these matters. To fulfil this role, the agency would have to be empowered to inspect certified banks and clinics and, in cases of non-compliance with the applicable standards, duties, restrictions or prohibitions, amend, revoke or suspend their certification.

RECOMMENDATION

22. (1) The federal, provincial and territorial governments, in conjunction with the professionals involved, should explore the possibility of establishing a national regulatory agency in the area of medically assisted procreation.

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761. The Warnock Report (*supra*, note 421, para. 13.3 at 79) recommended establishment of the Statutory Licensing Authority, a regulatory agency independent of the government. Among other things, the Authority would control and regulate infertility services, gamete and embryo storage, research, licences and a central registry. The Interim Licensing Authority has assumed these duties pending the adoption of a statute establishing the Statutory Licensing Authority. In November 1990, the Human Fertilisation and Embryology Authority was created under the *Human Fertilisation and Embryology Act 1990*, *supra*, note 421, s. 5. This agency should be fully operational in the summer of 1991 and should replace the Interim Licensing authority; see appendix A, *infra* at 199.

(2) The powers and duties of the national agency should be as follows:

(*a*) to grant certification;

(*b*) to set out in regulations the various standards, duties, restrictions and prohibitions referred to in recommendation 21(1) and to ensure compliance with those regulations;

(*c*) to establish a central registry;

(*d*) to identify problems on the basis of national data;

(*e*) to analyse the various success rates and compile statistics;

(*f*) to ensure long-term control through studies on the technical, medical and psychological aspects of medically assisted procreation;

(*g*) to prevent exploitation and commercialization in the area of medically assisted procreation;

(*h*) to promote any research and studies deemed necessary;

(*i*) to advise the various governments on these matters; and

(*j*) to inspect certified banks and clinics and, if need be, to amend, revoke or suspend their certification.

(3) The federal government should take the initiative of organizing meetings to discuss the establishment of such an agency.

Summary of Recommendations

1. Legislation governing access to medically assisted procreation technologies should respect the right to equality. Access should be limited only in terms of the cost and scarcity of resources. Where limitation is necessary, selection should not be based on unlawful grounds for discrimination within the meaning of federal and provincial legislation (family status, marital status, sexual orientation, and so on).

2. To eliminate the possibility of eugenic practices, the selection of gametes and embryos with specific qualities should be prohibited, except where the objective is to prevent the transmission of serious genetic diseases.

3. (1) All commercialization of the donation of gametes and embryos should be prohibited. Only reimbursement of reasonable expenses incurred by donors should be permitted.

(2) Gamete and embryo banks should not be permitted to operate on a profit basis. However, banks should be allowed to be reimbursed for reasonable costs related to their operations.

4. Surrogacy contracts must remain absolutely null and void. Further, acting as a paid intermediary in such an agreement should be a criminal offence.

5. (1) Before conceiving embryos for future personal use, the person or persons with control should be required to make a written statement of intentions as to the fate of the embryos in such circumstances as the death of a person with control, abandonment of the parental project, expiry of the time limit on freezing, or a divorce or other dispute between the persons with control. A person with control should be able to change, in writing, his or her stated intentions regarding the fate of the embryos as long as the embryos have not been used for their intended purpose; in cases where control over the embryos is shared by two people, both must agree to any changes.

(2) Control over embryos conceived using gametes from a couple should be exercised jointly by the partners. Control over embryos conceived using gametes from only one of the partners and a donor should vest in the partner genetically linked to the embryos. Control over embryos conceived with donated gametes should vest in the bank or clinic that has the embryos in its possession.

(3) The possible uses of embryos should be limited to implantation, experimentation and destruction; however, implantation should be prohibited beyond the time limit on freezing.

(4) The person with control over an embryo who decides to donate the embryo should be required, before the donation is made, to make a written statement expressing his or her consent to the donation, and stating the conditions attached to the donation respecting the utilization of the embryo. That person should also be able to change those conditions or withdraw consent by making a written statement to that effect at any time before the donated embryo is used; in cases where control over the embryo is shared by two partners, both must agree to any change.

6. (1) Control over gametes should vest in the producer.

(2) A person depositing his or her gametes for future personal use should be required, before the deposit, to make a written statement expressing his or her intentions as to the fate of the gametes in such circumstances as the death of the person with control, abandonment of the parental project or expiry of the time limit on freezing. The depositor should be able to change, in writing, his or her stated intentions regarding the fate of the gametes before any embryos are created or the gametes are used for their intended purpose.

(3) A person who donates his or her gametes should be required, before the donation is made, to make a written statement expressing his or her consent to the donation and stating the conditions attached to his or her donation respecting the use of the gametes. The donor should be able to change these conditions or withdraw his or her consent by making a written statement to that effect at any time before embryos are created or the donated gametes are used.

(4) Possible uses of gametes should be limited to fertilization, experimentation and destruction; fertilization should be prohibited beyond the time limit on freezing.

7. (1) Provincial parentage laws should reflect the intentions of couples who use medically assisted procreation; accordingly, actions to disavow paternity by a father who gave his consent or to challenge paternity by a third party on the grounds that a donation from a third person was used should not be allowed.

(2) It should not be possible to establish a bond of parentage between a donor and the child.

(3) Legislation that still makes a distinction between legitimate and illegitimate children should recognize children born as a result of medically assisted procreation as having the status of legitimate children.

8. Provincial succession laws should be harmonized to establish that children born as a result of the post-mortem use of gametes or embryos may not inherit unless there is a specific reference to that effect in the will of the deceased producer.

9. Clinics offering medically assisted procreation services should be required to submit written annual reports to a central registry; the minimum content of the reports should be set and the data should be presented in a prescribed form.

10. Uniform and mandatory standards for the selection, screening and storage of gametes and embryos, and the selection and screening of donors, should be developed at the national level.

11. Donated sperm should be frozen and should not be used for fertilization until the donor has been properly tested for evidence of the AIDS virus.

12. (1) Embryos should not be frozen for more than five years. Further, the federal government should encourage research on the effects of cryopreservation in order to reassess this five-year limit.

(2) Gametes should not be frozen for more than ten years. Further, the federal government should encourage research on the effects of cryopreservation in order to reassess this ten-year limit.

13. A limit should be placed on the number of times gametes from the same donor may be used. Further, the studies needed to set an appropriate limit should be encouraged.

14. The import of gametes and embryos should be restricted to certified banks. Imported gametes and embryos should have to meet Canadian standards.

15. Every effort should be made to reduce the risk of multiple pregnancy and to promote the development of technologies that follow the normal cycle of ovulation. Accordingly, the federal government should encourage studies and research aimed at reducing the multiple-pregnancy rate and developing technologies that follow the normal cycle of ovulation. Further, clinics should be required to document and justify the number of embryos implanted in each treatment cycle.

16. Every clinic offering medically assisted procreation services should be required to provide to persons using medically assisted procreation, either before, during or after the application of a technology, counselling services whereby these persons could obtain from experts (psychologists, physicians and so on) the assistance and information they might need concerning the specific problems involved in medically assisted procreation.

17. (1) Clinics should be required to keep records (on the donor, the mother and the child) that allow physicians to link the donor to the recipient while protecting the anonymity of the parties.

(2) Only the information needed to attain the following objectives should be collected: to permit access to medical and genetic information that may be needed to obtain optimum medical care; to meet the psychological needs of the child; to ensure proper clinical reports; and to permit studies on the long-term effects of the various technologies used in medically assisted procreation.

(3) Clinics should be responsible for protecting the confidentiality of the information they hold.

18. The legal parents or the child should be able to request disclosure of non-identifying information, in particular social information (such as ethnic origin, profession, education, religious affiliation and interests of the donor). However, identifying information should be disclosed only with the donor's consent.

19. It should be possible to reveal to the prosecuting authorities the identity of any donor who fails to provide information or who provides false information for the purpose of a criminal prosecution related to such false disclosure or failure to disclose.

20. Studies should be undertaken to determine and measure the long-term effects of medically assisted procreation technologies on the resulting children.

21. (1) A system of certification for clinics and banks should be established in order to regulate the following issues:

(*a*) national standards for the selection, screening and storage of gametes and embryos;

(*b*) the requirement to submit annual reports to a central registry and the content of the reports;

(*c*) the requirement to freeze donated sperm and use it only after the donor has been properly tested for evidence of the AIDS virus;

(*d*) the duty to justify in writing the number of embryos implanted per treatment cycle;

(*e*) the duty to establish counselling services and the composition and duties of such counselling services;

(*f*) the duty to keep medical records and the content of those records;

(*g*) the duty to establish a system that allows the physician to link donors to recipients while protecting the anonymity of the parties;

(*h*) the duties pertaining to access to identifying and non-identifying information;

(*i*) the restrictions pertaining to the allowable use and time limits on the freezing of gametes and embryos, the frequency of use of gametes from the same donor and the import of gametes and embryos;

(*j*) the prohibitions pertaining to the selection and commercialization of gametes and embryos; and

(*k*) the conditions attached to the donation of gametes and embryos, the notion of control over gametes and embryos, the manner in which the person having such control may express his or her intentions and the terms and conditions governing the exercise of such intentions.

(2) The application of medically assisted procreation technologies should be restricted to certified clinics, and only certified banks should be permitted to store, preserve and import gametes and embryos.

22. (1) The federal, provincial and territorial governments, in conjunction with the professionals involved, should explore the possibility of establishing a national regulatory agency in the area of medically assisted procreation.

(2) The powers and duties of the national agency should be as follows:

(*a*) to grant certification;

(*b*) to set out in regulations the various standards, duties, restrictions and prohibitions referred to in recommendation 21(1) and to ensure compliance with those regulations;

(*c*) to establish a central registry;

(*d*) to identify problems on the basis of national data;

(*e*) to analyse the various success rates and compile statistics;

(*f*) to ensure long-term control through studies on the technical, medical and psychological aspects of medically assisted procreation;

(*g*) to prevent exploitation and commercialization in the area of medically assisted procreation;

(*h*) to promote any research and studies deemed necessary;

(*i*) to advise the various governments on these matters; and

(*j*) to inspect certified banks and clinics and, if need be, to amend, revoke or suspend their certification.

(3) The federal government should take the initiative of organizing meetings to discuss the establishment of such an agency.

APPENDIX A

Comparative Study of Foreign and Canadian Texts Dealing with Medically Assisted Procreation

Introduction[1]

Medically assisted procreation has been the focus of numerous studies and reports in recent years. These studies and reports have led some countries to adopt new legislation. Before analysing the measures that have been recommended or adopted, we should briefly explain the initiatives taken in this area in countries other than Canada, as well as in Canada and in Quebec.[2]

In Australia, the state of Victoria was the first to pass general legislation regulating medically assisted procreation and surrogate motherhood.[3] The Commonwealth of Australia and other states have also enacted legislation,[4] and all Australian states have produced reports on medically assisted procreation.[5] Finally, the Family Law Council has issued recommendations on surrogacy contracts,[6] and the National Bioethics Consultative Committee has investigated the problems associated with access to information and with surrogacy.[7]

In Denmark, the Danish Council of Ethics broached the issue of medically assisted procreation in 1990.[8] In 1988, Spain passed a law on all medically assisted procreation

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1. The reader will find at the end of this appendix a list of the texts referred to, listed and numbered according to country, *infra* at 214-20.

2. For an overview of the state of the law around the world, see Jan Stepan, ed., *International Survey of Laws on Assisted Procreation* (Zurich: Schulthess Polygraphischer, 1990). See also EASTERN EUROPE 1.

3. VICTORIA 1. See also VICTORIA 2.

4. COMMONWEALTH OF AUSTRALIA 1; SOUTH AUSTRALIA 1 and SOUTH AUSTRALIA 2; WESTERN AUSTRALIA 1; NEW SOUTH WALES 1 and NEW SOUTH WALES 2; QUEENSLAND 1 and QUEENSLAND 2; TASMANIA 1; NORTHERN TERRITORY 1.

5. SOUTH AUSTRALIA 3; WESTERN AUSTRALIA 2; NEW SOUTH WALES 3, NEW SOUTH WALES 4 and NEW SOUTH WALES 5; QUEENSLAND 3; VICTORIA 3 and VICTORIA 4.

6. AUSTRALIA 1.

7. COMMONWEALTH OF AUSTRALIA 2 and COMMONWEALTH OF AUSTRALIA 3. In October 1990, the National Bioethics Consultative Committee released two discussion papers; see COMMONWEALTH OF AUSTRALIA 4 and COMMONWEALTH OF AUSTRALIA 5.

8. DENMARK 1; the report includes recommendations aimed at protecting human substances, and draft regulations on artificial insemination.

technologies, based on the work of the Council of Europe.[9] In 1989, the Council of Europe authorized the release of the report of its ad hoc Committee of Experts on Progress of Biomedical Sciences (CAHBI) in the hope that it would help harmonize the regulation of medically assisted procreation by member states.[10]

In the United States, some 30 states have passed legislation on the parentage of children born as a result of artificial insemination by donor (AID).[11] Louisiana and Pennsylvania have passed laws to regulate the clinical use of in vitro fertilization (IVF), and Ohio has done likewise for AID.[12] The increasingly frequent use of surrogacy has led to a number of statutes being passed[13] and to a large number of bills being introduced.[14] The New York Task Force on Life and the Law published recommendations and draft legislation on surrogacy in 1988,[15] and the American Fertility Society and its ethics committee have issued recommendations and guidelines on medically assisted procreation technologies.[16]

France has not passed any legislation on these matters, with the exception of *Décret n° 88-327*, which approaches medically assisted procreation from the perspective of professional control and hospital organization.[17] However, France's Conseil d'État released a report in 1988 dealing specifically with medically assisted procreation,[18] and a draft bill giving effect to the recommendations in the report has since been tabled in the French National Assembly.[19]

In 1987, the Norwegian parliament passed a law regulating artificial insemination and in vitro fertilization[20] on the basis of recommendations made in a legislative proposal.[21]

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9. See SPAIN 1. See also SPAIN 2 and SPAIN 3 at 241.
10. COUNCIL OF EUROPE 1. However, the committee did not give the report official recommendation status.
11. See, *e.g.*, LOUISIANA 1; MISSOURI 1, s. 210.824; NEW YORK 1, s. 1. See also UNITED STATES 5.
12. LOUISIANA 2, ss 121 to 133; PENNSYLVANIA 1, s. 3213; OHIO 1, ss 3111.30 to 3111.38. See also UNITED STATES 4 at 249; LOUISIANA 4, s. 1062.1, and DELAWARE 1, s. 2801, regarding tests to screen gamete donations; ILLINOIS 1, para. 6(7), regarding the sale of and experimentation on fetuses; TEXAS 1, s. 3A, regarding insurance coverage of services.
13. See, *e.g.*, ARKANSAS 1, s. 9-10-201; INDIANA 1, ss 31.8.1.2 to 31.8.2.1; KENTUCKY 1; LOUISIANA 3; MICHIGAN 1, ss 722.853 to 722.861; NEBRASKA 1; NEVADA 1, ss 127.287 and 127.288. See also UNITED STATES 3.
14. See NEW YORK 2 at 99 n. 13. See also draft legislation in the following states: Alabama, Arizona, Connecticut, Delaware, Florida, Illinois, Iowa, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New Jersey, New York, North Carolina, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Wisconsin.
15. See the *Proposed Surrogate Parenting Act*, NEW YORK 2 at A-1.
16. Only the most recent recommendations are cited; see UNITED STATES 1 and UNITED STATES 2.
17. FRANCE 1.
18. FRANCE 6.
19. See FRANCE 5. The proposed legislation amends the *Code de la santé publique* (FRANCE 2), the *Code civil* (FRANCE 3) and the *Code pénal* (FRANCE 4). The affected provisions are cited following each section of the preliminary draft legislation.
20. NORWAY 1.
21. NORWAY 2.

In the United Kingdom, the *Surrogacy Arrangements Act 1985*[22] deals with surrogate motherhood, while the *Human Fertilisation and Embryology Act 1990*[23] covers all the technologies used in medically assisted procreation. The latter statute followed the recommendations of the first significant study in this area, carried out under the direction of Dame Mary Warnock,[24] which produced a legislative proposal, the White Paper.[25] Further, annual reports are prepared by the Interim Licensing Authority,[26] an agency established as a result of the Warnock report that operates without enforcing authority.

The Riksdag in Sweden passed legislation on artificial insemination in 1984[27] and IVF in 1988.[28] In December 1990 the parliament of the former Federal Republic of Germany passed a law aimed primarily at protecting embryos and preventing "misuse" of medically assisted procreation.[29]

In Canada, the first published studies dealt only with artificial insemination. The report of British Columbia's Royal Commission on Family and Children's Law was released in 1975,[30] while the report of the Advisory Committee on the Storage and Utilization of Human Sperm was submitted to the Minister of National Health and Welfare in 1981.[31]

The issue of medically assisted procreation was first addressed as a whole in a 1985 report by the Ontario Law Reform Commission. The underlying principle was that the state should not intervene in matters of procreation, but the report concluded that legislative intervention was needed because of the implications of medically assisted procreation for people other than the prospective parents.[32]

In March 1987, the Law Reform Commission of Saskatchewan released a short report and a proposal for legislation on artificial insemination that focused primarily on the legal status of the child and the donor.[33]

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22. UNITED KINGDOM 1.
23. UNITED KINGDOM 2.
24. UNITED KINGDOM 5.
25. UNITED KINGDOM 6.
26. UNITED KINGDOM 4. See also UNITED KINGDOM 3.
27. SWEDEN 1. Regulations have also been adopted, see SWEDEN 3.
28. SWEDEN 2. See also SWEDEN 4 and SWEDEN 5 at 387.
29. See GERMANY 1.
30. BRITISH COLUMBIA 1.
31. CANADA 3.
32. ONTARIO 1 at 119-20.
33. SASKATCHEWAN 1.

In June 1989, the British Columbia Branch of the Canadian Bar Association released a report on medically assisted procreation; the main elements of the report were adopted as basic CBA policy in March 1990.[34]

In its February 1990 report, the Canadian Advisory Council on the Status of Women took a different approach to medically assisted procreation, giving primary consideration to the prevention of infertility.[35]

Finally, the Canadian Fertility and Andrology Society issued guidelines on artificial insemination by donor in 1988[36] and recently co-published with the Society of Obstetricians and Gynaecologists of Canada an analysis of all medically assisted procreation technologies.[37]

In Quebec, the ad hoc committee of the Barreau du Québec issued its recommendations on medically assisted procreation in April 1988.[38] In 1988[39] and April 1989,[40] the Department of Health and Social Services released reports dealing respectively with the incorporation of the technologies in the Quebec health-care system and the approach to be taken in this area. And finally, the Conseil du statut de la femme has since 1985 been focusing special attention on medically assisted procreation. Seven reports and various communiqués collected during an international forum organized by the Council were used to prepare an overview of the issues[41] that was submitted to the Quebec government in May 1989. In December 1990, the Minister of Justice of Quebec tabled Bill 125, *Civil Code of Québec*, five articles of which deal specifically with medically assisted procreation.[42]

Many important initiatives have been taken in an effort to understand the implications of medically assisted procreation. The substance of the measures that have been taken or recommended is analysed in three main sections: general principles; safety of medically assisted procreation technologies; and medical control and regulation.

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34. CANADA 2.

35. CANADA 1. The report treats medically assisted procreation as experimentation.

36. CANADA 4.

37. CANADA 5.

38. QUEBEC 1.

39. QUEBEC 5. In a dissenting opinion in the 1988 report, Francine McKenzie criticized the liberalism that characterizes the determination of infertility (one year of sexual intercourse without contraception) and the selection of candidates (candidates may already have had children or been voluntarily sterilized). She condemned the relentless procreative activity to which women may fall victim, the trivialization of the serious social risks inherent in assisted reproduction technologies, and the triumph of technology over human concerns, and expressed her opposition to the expansion of and additional funding for fertility clinics in Quebec. See *Opinion synthèse de Madame McKenzie*, issued in a press release from the Conseil du statut de la femme, 18 April 1988.

40. QUEBEC 6.

41. QUEBEC 4; see also QUEBEC 3.

42. QUEBEC 7, arts 579 to 583.

I. General Principles

Some aspects of medically assisted procreation involve choices with respect to principles and values. These aspects include access, commercialization, surrogacy, control over gametes and embryos, and parentage.

A. Access

Access to medically assisted procreation is a major issue addressed in most of the legislation and reports that deal with the matter. Restrictions are common, and France's Conseil d'État goes so far as to recommend criminal sanctions against physicians who violate them.[43] However, some countries suggest that no criteria be imposed and that the decision on access be left to the physician.[44] Where criteria are used, there are two types: personal and medical.

1. Personal Criteria

The personal criteria most often considered in determining access include marital status, sexual orientation, stability and spousal consent.

The marital status of those who wish to use the technologies is not a restrictive criterion. Except in Norway,[45] the laws and reports do not require that couples be actually married.

The sexual orientation of the couple and whether or not the prospective parents are a couple are criteria that severely restrict access. A number of countries recommend that only heterosexual couples be accepted.[46] However, the Ontario Law Reform Commission report allows single women access,[47] and the reports of the Quebec Department of Health and Social Services[48] and the American Fertility Society[49] would give women access to artificial insemination regardless of their status. Spanish statutes,[50] the Canadian

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43. FRANCE 5, s. 10 — FRANCE 2, L. 675. See also NEW SOUTH WALES 1, s. 9, NEW SOUTH WALES 3, para. 6.14, rec. 8, and NEW SOUTH WALES 4, rec. 9 at 66-67, which provide that physicians who fail to consider certain factors in their choice of treatment are deemed to have engaged in "professional misconduct."

44. UNITED KINGDOM 5, rec. 24 at 82, and UNITED KINGDOM 6, para. 78; CANADA 1 at 26-27, and CANADA 2 at 22.

45. NORWAY 1, s. 4. It should be noted that the draft legislation gave access to unmarried couples.

46. See, *e.g.*, SOUTH AUSTRALIA 2, ss 13(3), 13(4) and 13(7); VICTORIA 1, ss 10 to 13A; this policy would not apply to AI. COUNCIL OF EUROPE 1, guideline 1; FRANCE 5, s. 10 and pp. 27-28 — FRANCE 2, L. 668-10 and L. 675; NORWAY 1, s. 4; SWEDEN 1, s. 2, SWEDEN 2, s. 2, and SWEDEN 5 at 388; QUEBEC 1 at 36-37, rec. 3, QUEBEC 4 at 13, recs 2.1 and 3.1, and QUEBEC 5, rec. 38 (for IVF). See also, table 1, *infra* at 201-202.

47. ONTARIO 1, rec. 5.

48. QUEBEC 5, rec. 11, allowing [TRANSLATION] "single women, whatever their status."

49. UNITED STATES 1, guideline IV.

50. SPAIN 1, s. 6, SPAIN 2 at 237, and SPAIN 3 at 242.

Fertility and Andrology Society[51] and the Danish Council of Ethics[52] all accept single women or women who are part of a homosexual couple. Finally, some countries do not exclude single women.[53]

The stability of the couple[54] and the spouse's consent to the procedure[55] are sometimes required.

2. Medical Criteria

The medical criteria most commonly used in determining access include medical and social assessment, infertility and the transmission of genetic disorders.

A medical assessment, possibly including psychological and social evaluation, is sometimes mandatory,[56] and evaluation of the welfare of the unborn child is recommended in some instances.[57]

It is often stated that those who wish to obtain access to artificial procreation technologies must be infertile, sterile or likely to transmit a genetic disease.[58] For

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51. CANADA 4 at 10; CANADA 5 at 28, rec. 11: "[D]ecision to restrict access to treatment should not be based on discriminating or stereotypical judgments."

52. DENMARK 1 at 95, rec. 5.1 at 124 and reg. 2.1 at 131.

53. UNITED STATES 2 at 24S; UNITED KINGDOM 2, ss 13(6); BRITISH COLUMBIA 1, recs 3, 4, 5 and 14 : favours adoption access criteria. NEW SOUTH WALES 1, ss 3(1), 7(2)d and 9, NEW SOUTH WALES 3 at 43-44, para. 6.14 and rec. 7, and NEW SOUTH WALES 4, rec. 7 at 65 (however, the following factors must be considered: whether the woman is part of a couple; the infertility of the couple or the risk of transmission of a genetic disorder; the welfare and interest of the child; the stability of the family; the need for counselling; age and physical and mental health of the prospective parent(s)).

54. See, *e.g.*, NEW SOUTH WALES 1, s. 9, NEW SOUTH WALES 3, para. 6.14, rec. 7, and NEW SOUTH WALES 4, rec. 7 (stability considered but not necessarily conclusive); ONTARIO 1, rec. 5, and CANADA 4 at 10; QUEBEC 1 at 36. See also, table 2, *infra* at 203-205. *Contra*: CANADA 1 at 26-27.

55. VICTORIA 1, ss 10 to 13A (this requirement does not apply in the case of AI) and QUEENSLAND 3, rec. B(2) (vii); DENMARK 1, reg. 1.1 at 131; SPAIN 1, s. 6, SPAIN 2 at 237, and SPAIN 3 at 242; OHIO 1, ss 3111.34 and 3111.35, and UNITED STATES 1, guideline IV; FRANCE 5, s. 10 and p. 28; FRANCE 2, L. 668-11 and L. 675; NORWAY 1, s. 4; UNITED KINGDOM 5, recs 21, 22 and 27 at 82-83; SWEDEN 1, s. 2, SWEDEN 2, s. 2, SWEDEN 3 and SWEDEN 5 at 388-89; BRITISH COLUMBIA 1, rec. 1, and CANADA 3 at 27 and rec. 3.4. *Contra:* NEW SOUTH WALES 3, rec. 10, and NEW SOUTH WALES 4, rec. 8 at 65-66; CANADA 2 at 15.

56. VICTORIA 1, s. 18; NEW SOUTH WALES 1, s. 9, NEW SOUTH WALES 3, para. 6.14, rec. 7, and NEW SOUTH WALES 4, rec. 7 at 65 (the medical assessment is considered but not mandatory); SPAIN 1, ss 2 and 6; NORWAY 1, s. 5; SWEDEN 1, s. 3; BRITISH COLUMBIA 1, recs 3, 4, 5 and 14. *Contra*: QUEBEC 5, rec. 39 (the requirements cannot be stricter than for natural procreation).

57. NEW SOUTH WALES 1, s. 9, NEW SOUTH WALES 3, para. 6.14, rec. 7, and NEW SOUTH WALES 4, rec. 7 at 65; VICTORIA 1 (see s. 1(9), schedule 3, of the *Infertility (Medical Procedures) Regulations 1988*); COUNCIL OF EUROPE 1, guideline 1; UNITED KINGDOM 2, para. 13(5); SWEDEN 1, s. 3.

58. SOUTH AUSTRALIA 2, paras 13(3) and 13(7); NEW SOUTH WALES 1, s. 9, NEW SOUTH WALES 3, para. 6.14, rec. 7, and NEW SOUTH WALES 4, rec. 7 at 65 (couples only, must be considered but is not mandatory); QUEENSLAND 3, recs B(2) (i) and B(2) (ii); VICTORIA 1, ss 10 to 13A (except for AI); COUNCIL OF EUROPE 1,

example, several states in Australia require one to two years of alternative treatment,[59] and the report by the Quebec Conseil du statut de la femme recommends increasing from one year to two years the period of unprotected intercourse without conception needed to prove infertility.[60] With respect to the transmission of genetic disorders, France's Conseil d'État requires a high probability of transmitting an incurable disorder,[61] the Council of Europe a serious genetic disorder or disease which, in the opinion of the attending physician, would result in early death or severe disability.[62]

Finally, choosing the sex of the child is not normally permitted unless there is a risk of transmitting a serious sex-linked hereditary disease,[63] and "minimal" matching of the donor's features with those of the spouse of the inseminated woman is generally advised.[64]

B. Commercialization

The laws and recommendations of many countries prohibit the commercialization of medically assisted procreation. The prohibition may be stated in general terms, or specific reference may be made to the gratuity of donations or to prohibition of the sale of gametes and embryos.[65] Compensation is therefore limited to reimbursement of the reasonable expenses incurred by donors (traveling expenses, medical expenses, lost income).[66]

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guideline 1; FRANCE 5, s. 10 and pp. 26-27; FRANCE 2, L. 668-10 and L. 675-1; NORWAY 1, ss 8 to 12; ONTARIO 1, rec. 1 (except for single women); QUEBEC 1 at 36 and rec. 3, QUEBEC 4 at 13 and rec. 2.1, and QUEBEC 5, recs 11 and 38 (for AID). It should be noted that some jurisdictions accept the techniques as treatments for infertility but in their recommendations on access do not require infertility. See, *e.g.*, UNITED KINGDOM 5, recs 4 to 7 and 28 at 80 and 83.

59. VICTORIA 1, ss 10 to 13A, VICTORIA 4, para. 3.6 and QUEENSLAND 3, rec. B(2) (ii).

60. QUEBEC 4 at 10 and recs 1.5, 2.1 and 3.1. See also QUEBEC 5, rec. 2, which suggests reviewing the one-year period.

61. FRANCE 5, s. 10 — FRANCE 2, L. 668-10.

62. COUNCIL OF EUROPE 1, guideline 1.

63. UNITED STATES 2 at 20S; UNITED KINGDOM 5, paras 9.11, 9.12 and rec. 29 at 83; COUNCIL OF EUROPE 1, guideline 1; GERMANY 1, s. 3; CANADA 5 at 46-47, rec. 28. QUEBEC 4 at 13 and rec. 2.6, QUEBEC 5, rec. 12. *Contra*: ONTARIO 1, rec. 28.

64. UNITED KINGDOM 5, para. 4.21; COUNCIL OF EUROPE 1 at 19-20; UNITED STATES 1, guideline VIII and OHIO 1, s. 3111.35; CANADA 4 at 6-7; CANADA 5 at 30, rec. 13; QUEBEC 5, rec. 16.

65. NEW SOUTH WALES 1, s. 12; VICTORIA 1, ss 11 to 13A; DENMARK 1, rec. 11.1 at 127; SPAIN 1, ss 5 and 20; COUNCIL OF EUROPE 1 at 25 and guidelines 9(1) and 9(2); ILLINOIS 1, para. 6(7); LOUISIANA 2, s. 122; FRANCE 5, s. 10 — FRANCE 2, L. 668-6 and L. 668-13; UNITED KINGDOM 2, s. 12 and para. 41(8), and UNITED KINGDOM 4, guideline 15d); SWEDEN 1, s. 7, and SWEDEN 2, s. 4; CANADA 1 at 28; QUEBEC 1 at 23, and recs 3 and 7, QUEBEC 4 at 13, rec. 2.4, QUEBEC 5, recs 20, 51 and 53, QUEBEC 6 at 61, and QUEBEC 7, art. 25.

66. NEW SOUTH WALES 1, s. 12, and NEW SOUTH WALES 3, para. 10.9, rec. 24; QUEENSLAND 3, rec. C(5)(vi); VICTORIA 1, ss 11 to 13A, and appendix 4, s. 3; COUNCIL OF EUROPE 1, guideline 9(1); UNITED STATES 1, guideline VII(C), and UNITED STATES 2 at 45S, 49S and 52S; FRANCE 5, s. 10 FRANCE 2, L. 668-6 (lost income is not covered); UNITED KINGDOM 5, para. 4.27, rec. 26 at 82, and UNITED KINGDOM 6, para. 63; BRITISH COLUMBIA 1 at 23; ONTARIO 1, rec. 15; CANADA 3 at 27, CANADA 4 at 9, and CANADA 5 at 41, rec. 25; QUEBEC 1 at 23, and QUEBEC 5, rec. 21.

Where they are mentioned, gamete and embryo banks that operate for profit are generally prohibited.[67] However, the Ontario report would allow duly licensed and regulated gamete banks to operate on a commercial basis, subject to government control. A fee comprising expenses and perhaps a reasonable profit would be established, but sales would be restricted to physicians, hospitals and other licensed banks.[68]

C. Surrogacy

The countries that have taken a position on surrogacy have chosen to ban, discourage or, in very rare cases, regulate the practice.

A complete prohibition of all forms of surrogacy is relatively rare.[69] Instead, countries try to discourage surrogate motherhood and to tackle the commercial aspect of the practice. Thus, they prohibit even non-commercial activity by agencies or other intermediaries;[70] the use of any advertising related to surrogate motherhood;[71] and paying or accepting any financial or other compensation in connection with a surrogacy contract.[72]

Other countries do not prohibit surrogacy, permit gratuitous contracts, or have refrained from passing legislation to counter private agreements. Accordingly, intermediaries working

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67. See, *e.g.*, COUNCIL OF EUROPE 1 at 25 and guideline 9(2) (costs of collection, retrieval, storage, implantation and medical services may be reimbursed); FRANCE 5, s. 10 — FRANCE 2, L. 668-13; QUEBEC 5, rec. 53, and QUEBEC 6 at 61. See also the general prohibitions in the preceding notes.

68. ONTARIO 1, recs 17 and 18: the suggested approach is similar to that used by the Canadian Red Cross Society. See also CANADA 5 at 39, rec. 23, which recommends that, in the absence of adequate public funding, commercial banks be established.

69. GERMANY 1, s. 1(1)7; FRANCE 5, s. 16 — FRANCE 4, s. 353.1; QUEENSLAND 2, ss 2 and 3; QUEBEC 1 at 27-30 and rec. 17. See also DENMARK 1 at 100, which opposes surrogate motherhood but does not propose changes to criminal legislation on the matter. With respect to U.S. law, see UNITED STATES 3.

70. SOUTH AUSTRALIA 1, s. 10h; NEW SOUTH WALES 5, recs 5 and 6 at 44-53; VICTORIA 1, s. 30; AUSTRALIA 1, rec. 17 and para. 6.6.16; COUNCIL OF EUROPE 1, guidelines 15(1), 15(3) and 15(4); MICHIGAN 1, s. 722.859, section 9; NEW YORK 2 at 126, s. 3 of the *Proposed Surrogate Parenting Act*; FRANCE 5, s. 16 and pp. 31-32 — FRANCE 4, s. 353.1; UNITED KINGDOM 1, s. 2, UNITED KINGDOM 5, para. 8.18 and rec. 58 at 86, and UNITED KINGDOM 6, para. 73; QUEBEC 1, recs 18 and 20, QUEBEC 4 at 21 and rec. 4.1, QUEBEC 5, recs 56 and 57, and QUEBEC 6 at 60.

71. See, *e.g.*, SOUTH AUSTRALIA 1, s. 10h; NEW SOUTH WALES 5, rec. 4 at 43-44; QUEENSLAND 2, s. 3; VICTORIA 1, s. 30; AUSTRALIA 1, para. 6.6.16; COUNCIL OF EUROPE 1, guideline 15(3); UNITED KINGDOM 1, para. 3(1); QUEBEC 4 at 21 and rec. 4.2, QUEBEC 5, rec. 56, and QUEBEC 6 at 60.

72. SOUTH AUSTRALIA 1, ss 10g and 10h (for intermediaries); NEW SOUTH WALES 5, rec. 3 and pp. 40-43; QUEENSLAND 2, s. 3; VICTORIA 1, s. 30; AUSTRALIA 1, rec. 17 and para. 6.6.15; COUNCIL OF EUROPE 1, guideline 15(4); MICHIGAN 1, s. 722.859, section 9, and NEW YORK 2 at 126, s. 3 of the *Proposed Surrogate Parenting Act* (except costs permitted in adoption, medical and legal costs, excludes lost wages); UNITED KINGDOM 1, s. 2(3) (except payment to the surrogate mother); CANADA 1 at 28, and CANADA 2, pp. 26-33, and rec. 9(d). *Contra*: NEVADA 1, s. 127.287. See also UNITED STATES 3.

free of charge or on a not-for-profit basis are not prohibited.[73] Reimbursement limited to expenses is possible.[74] In certain cases the parties themselves cannot be prosecuted.[75] Finally, the most frequently recommended measure is to make surrogacy contracts unenforceable in a court of law or declare them null and void.[76]

The American Fertility Society allows surrogate motherhood for strictly medical reasons and views it as a clinical experiment that has to be studied in detail. The parties would be informed of the psychological risks surrogacy may entail.[77]

The report of the Ontario Law Reform Commission recommends the legalization of regulated agreements. A major role is assigned to the courts, which would have to approve agreements before conception but after evaluating the parenting abilities of the future parents, their stability as individuals and as a couple, and the medical reasons for using the procedure. The judge would also have to consider the prospective surrogate: physical and mental health, marital situation and partner's opinion, and the impact on any other children. He or she would have to ensure that blood tests are performed in order to prevent

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73. SOUTH AUSTRALIA 1, s. 10h; VICTORIA 1, s. 30; MICHIGAN 1, s. 722.859; NEW YORK 2 at 126, s. 3 of the *Proposed Surrogate Parenting Act* (the physician may be paid for his or her services); UNITED STATES 2 at 67S; UNITED KINGDOM 1, s. 2.

74. MICHIGAN 1, s. 722.853, section 3a; NEW YORK 2 at 126, s. 3 of the *Proposed Surrogate Parenting Act* (excludes lost wages); UNITED STATES 2 at 67S (accepts the possibility of higher payment); UNITED KINGDOM 1, para. 2(3) (excludes payment received by surrogate mother); ONTARIO 1 at 253-55, rec. 51; CANADA 5 at 42, rec. 26.

75. UNITED KINGDOM 5, para. 8.19, and UNITED KINGDOM 6, para. 73; QUEBEC 5, rec. 57; GERMANY 1, s. 1: [TRANSLATION] "Anyone will be punished with up to three years imprisonment, or a fine, who: . . . (vii) attempts to perform artificial insemination or embryo transfer on a woman prepared to permanently give up her child after birth (surrogate mother)." However, subsection (3) excludes the surrogate mother and the social parents from the application of the Act: [TRANSLATION] "(3) . . . in the case of section I(vii), the surrogate mother and the person who wishes to take long-term care of the child will not be punished." However, in other countries, parties may be prosecuted where there is payment or advertising; see *infra*, table 4 at 210-13.

76. SOUTH AUSTRALIA 1, s. 10g; NEW SOUTH WALES 5, rec .8 at 55-60; QUEENSLAND 2, s. 4; VICTORIA 1, para. 30(3); AUSTRALIA 1, rec. 17 and para. 6.6.15; COMMONWEALTH OF AUSTRALIA 3 at 36; SPAIN 1, s. 10, SPAIN 2 at 237 and SPAIN 3 at 242; COUNCIL OF EUROPE 1, guideline 15(2); INDIANA 1, s. 31.8.2.1; MICHIGAN 1, s. 722.855, section 5; NEW YORK 2, s. 2 of the *Proposed Surrogate Parenting Act*; FRANCE 5, s. 11 — FRANCE 3, s. 342-12; UNITED KINGDOM 2, para. 36(1) (which amends the *Surrogacy Arrangements Act 1985*), UNITED KINGDOM 5, para. 8.19, rec. 59 at 86, and UNITED KINGDOM 6, para. 73; CANADA 2, rec. 9(b) (the surrogacy contract would be valid but not binding on the surrogate); QUEBEC 1, rec. 18, and QUEBEC 7, art. 582. See also UNITED STATES 3.

77. UNITED STATES 2 at 67S. Similarly, see CANADA 5 at 27, rec. 10:

> The Societies recommend:
> 1. that surrogacy be permitted for medical reasons; and
> 2. that ongoing research be conducted to carefully evaluate the impact of surrogacy on all parties involved.

See also COUNCIL OF EUROPE 1, guidelines 11 and 15(4) (the Council leaves member states free to decide whether or not to prohibit).

any subsequent challenge respecting the child's parentage, approve any possible payment and ensure that the parties agree on the following matters: insurance, death or separation of the applicants, behaviour and diet before and during the pregnancy, diagnostic examinations, terms and conditions for transferring the child, and future relations between the surrogate and the child.[78]

D. Control over Gametes and Embryos

Recommendations on control over gametes and embryos often differ considerably from country to country. For example, some countries hold the view that donors have a property right over their gametes,[79] while others feel that the legal system applicable to embryos is that of persons.[80] Louisiana even grants legal existence to in vitro embryos until they are implanted.[81] The extent to which the various parties may control gametes and embryos is examined from two different perspectives: the exercise of control and post mortem fertilization.

1. The Exercise of Control

Generally, control of human products is exercised through a consent form which indicates how gametes and embryos may be used.

(a) Consent

Consent to the donation and storage of gametes and embryos must in most cases be written and sometimes requires the signatures of both partners.[82] Some countries require that the consent form signed at the time of the donation include the conditions under which

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78. ONTARIO 1, recs 34 to 66; hearings must be held *in camera*, and agencies would be regulated. It should also be noted that one Commissioner objected to the legalization of surrogacy itself: *ibid.* at 287-91. COMMONWEALTH OF AUSTRALIA 3 at 36: it is recommended that surrogacy not be prohibited altogether, but that its application be strictly controlled.

79. NEW SOUTH WALES 3, para. 10.14, and NEW SOUTH WALES 4, rec. 23i) at 86. See, however, UNITED KINGDOM 5, paras 10.11 and 11.17, recs 42 and 62 at 84 and 86, where it is proposed that the embryo be afforded legal protection, without there being property rights over human embryos, and CANADA 2, rec. 10(d) (human tissue not to be treated as a commodity).

80. QUEBEC 1 at 15; FRANCE 5 at 34.

81. LOUISIANA 2, ss 123-126: the *in vitro* embryo is a legal person, and may take or be subject to legal action through a guardian.

82. QUEENSLAND 3, rec. B(3) (xix), VICTORIA 1, ss 9 to 13A; DENMARK 1, recs 6.1 and 7.1 at 124-25, reg. 3.1 at 132; COUNCIL OF EUROPE 1 at 21-22 and guidelines 4 and 9(3); UNITED STATES 2 at 60S, and UNITED STATES 1, guideline VII(C); FRANCE 5, s. 10 — FRANCE 2, L. 668-5; UNITED KINGDOM 4, guidelines 15 and 16 and UNITED KINGDOM 6, para. 55; BRITISH COLUMBIA 1, recs 9 and 10, CANADA 3 at 27, rec. 3.4, ONTARIO 1, rec. 12, and CANADA 4 at 9-11.

the gametes may be used, stored or destroyed,[83] and that consent to storage include the respective wishes of each partner in the event of death, disagreement or divorce.[84]

Control over gametes can also be regulated through specific provisions. When the producer dies, at the end of the storage period or if the producer cannot be located, three options are open: the gametes can be destroyed;[85] control can revert to the storing agency, which must comply with the expressed wishes of the producer;[86] or the gametes may be used or destroyed at the discretion of the storing agency.[87]

With respect to stored embryos, the same three options are open when the couple dies, at the end of the storage period, in case of disagreement, or if the couple cannot be located: the embryos may be destroyed;[88] control may revert to the storing agency, which must comply with the wishes of the couple;[89] or the embryos may be used or destroyed at the discretion of the storing agency.[90] If only one of the partners dies, the embryos are destroyed[91] or control reverts to the surviving partner.[92]

According to the report of the Ontario Law Reform Commission, an embryo produced by a donor and one of the partners would be subject to the exclusive control of the couple. Control of an embryo produced from two donations would rest with the agency that has the embryo in its possession until the embryo is implanted in the woman for whom it was produced.[93]

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83. South Australia 2, s. 10(3); Victoria 1, ss 11 to 13A and New South Wales 3, para. 10.18, rec. 26; Spain 1, s. 5; France 5, s. 10 — France 2, L. 668-11 and L. 668-12; United Kingdom 2, appendix 3, ss 2, 3, 6 and 8, United Kingdom 4, guideline 15d), and United Kingdom 6, para. 55; Ontario 1, recs 13 and 14; Canada 5 at 31, rec. 14.

84. United States 2 at 60S; United Kingdom 2, appendix 3, ss 2 and 3, and United Kingdom 6, para. 60; Canada 5 at 40, rec. 24; Quebec 5, recs 47 and 48.

85. Denmark 1 at 97 and rec. 6.1 at 124; Council of Europe 1 at 23-24 and guideline 7; France 5, s. 10 — France 2, L. 668-3; United Kingdom 2, s. 14, and United Kingdom 6, para. 57; Quebec 1, rec. 9. *Contra*: Quebec 5 at 49, rec. 35.

86. New South Wales 3, para. 10.18, and rec. 26; United Kingdom 6, para. 57.

87. United Kingdom 5, para. 10.8, rec. 60 at 86.

88. New South Wales 4, recs 2 and 22; Denmark 1, rec. 6.1 at 124; Council of Europe 1 at 24-25 and guideline 8; France 5, s. 10 — France 2, L. 670; United Kingdom 2, s. 14, and United Kingdom 6, paras 57, 58 and 60; Ontario 1, rec. 32; Quebec 1 at 34.

89. United Kingdom 6, paras 57, 58 and 60. See also New South Wales 4, para. 5.51, which calls for the status quo until the end of the storage period in cases of disagreement.

90. New South Wales 4, recs 2 and 26; United Kingdom 5, para. 10.10, rec. 32 at 83; Ontario 1, rec. 27(1). See, however, Quebec 5, rec. 48, where an ethics committee would decide the fate of the embryos if the couple could not be located, if there were disagreement or if the parental plan were abandoned.

91. Denmark 1 at 101, rec. 6.1 at 124; France 5, s. 10 — France 2, L. 670; United Kingdom 6, para. 60.

92. New South Wales 4, recs 2 and 25; United Kingdom 5, para. 10.12, rec. 33 at 83, and United Kingdom 6, para. 59; Ontario 1, rec. 27(1).

93. Ontario 1, recs 27(1) and 27(2).

As a rule, explicit consent to any use of gametes and embryos is required, and the wishes expressed by the producers must be respected.[94] The conditions stated at the time gametes are donated may also apply to any embryos produced with those gametes,[95] but an unconditional donation deprives the donor of all control over the use of his or her gametes and any embryos that may result.[96]

The Council of Europe permits donations accompanied by reasonable, non-discriminatory conditions,[97] whereas the Barreau du Québec opposes any donation that includes conditions with which the recipient or couple must comply.[98] Donations to a specific person are sometimes prohibited,[99] but in other jurisdictions there is no objection where regular safety precautions are taken.[100] Consent can generally be changed or withdrawn before the donation is used,[101] although some countries consider it to be irrevocable.[102]

(b) Use of Gametes

Gamete donation is often restricted. The laws of Sweden and Norway prohibit the donation of ova and sperm for in vitro fertilization.[103] The Barreau du Québec would permit the donation of gametes where they are to be used for therapeutic purposes.[104] The Council of Europe states that for purposes of IVF it is preferable to use gametes from the couple.[105] One Quebec report suggests prohibiting ovum donation,[106] while another would place restrictions on such donations: the ovum could not be retrieved solely for the purpose of being donated, and the ovum must come from a woman who is undergoing

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94. New South Wales 1, s. 13, New South Wales 4, recs 2, 23 and 24; Victoria 1, ss 9 to 13A; Denmark 1, rec. 4.1 at 123, reg. 4.2 at 132; Spain 1, ss 13 to 15; Council of Europe 1 at 25, and guidelines 8(3) and 17(2); United States 2 at 36S and 60S, Louisiana 2, ss 126 and 130; France 5, s. 10 — France 2, L. 668-12, L. 668-13, L. 669, L. 671, L. 672 and L. 676-2; United Kingdom 2, appendix 3, s. 5, United Kingdom 4, guidelines 5 and 6, and United Kingdom 5, para. 11.24, recs 13 and 14 at 81, United Kingdom 6, paras 51 and 56; Germany 1, s. 4; Ontario 1, rec. 12; Canada 2, rec. 10(b); Quebec 1, recs 23, 25 and 27, and Quebec 5, recs 45, 47 and 50.

95. Council of Europe 1, guideline 17(2); United Kingdom 2, appendix 3, ss 2 and 6; Ontario 1, recs 13, 26 and 27(2).

96. New South Wales 3, para. 10.13, and New South Wales 4, rec. 23; Ontario 1, rec. 27(2).

97. Council of Europe 1 at 25 and guideline 9(3); for example, using gametes in another geographic region.

98. Quebec 1 at 24.

99. United Kingdom 4, guideline 13(j), which advises against gamete donations from known persons or close relatives; France 5, s. 10 and p. 25 — France 2, L. 668-7; Quebec 1 at 24.

100. New South Wales 3, para. 8.4; Victoria 1, s. 16; United States 2 at 49S-50S and 52S; United Kingdom 5, para. 6.7; see also Quebec 5 at 43.

101. Victoria 1, ss 11 to 13A and 15; Council of Europe 1, guideline 9(3); United Kingdom 2, appendix 3, s. 4, United Kingdom 4, guideline 15(b), and United Kingdom 6, para. 57; Ontario 1, recs 13 and 14.

102. South Australia 3 at 25; Denmark 1 at 99. See also Spain 1, s. 5, where the subsequent sterility of the donor is the only ground for revocation; the donor must then repay the costs incurred by the recipient.

103. Sweden 2, s. 2; Norway 1, s. 12.

104. Quebec 1 at 23.

105. Council of Europe 1 at 26 and guideline 11(1). See also Denmark 1, recs 7.1a and 7.1b at 125 (minority proposal).

106. Quebec 4 at 17, rec. 3.1.

infertility treatment and has enough ova to meet her own needs.[107] Finally, many jurisdictions require, or at least recommend, that sperm from only one donor be used for insemination in any given cycle.[108]

The use of gametes from minors is generally discouraged.[109] Ontario, however, does not object to sperm donations from minors but would not allow ovum donation unless there were informed consent and the ovum were donated at the time of a hysterectomy or other operation.[110] By and large, experimentation on gametes does not raise any problems.[111]

(c) Use of Embryos

Some countries are opposed to embryo donation,[112] while others make embryo donation subject to specific conditions: donors must have resolved their fertility problems, and the recipient couple must be in treatment;[113] donation must be restricted to special circumstances, in particular preventing the embryo from being destroyed or undergoing experimentation,[114] unless consent to donation is given prior to fertilization.[115]

The creation of embryos is often limited to procreation[116] or treatment for the couple; embryos cannot therefore be created solely for the purpose of being donated.[117] Implantation in the same person of embryos from different donors would be permitted by the Ontario Law Reform Commission,[118] but is rejected by some countries.[119]

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107. Quebec 5, recs 50 and 51; see also Germany 1, ss 1(1)i and ii.

108. New South Wales 3, para. 9.24, recs 22 and 23; Victoria 1, s. 26; Spain 1, s. 20; Sweden 3; Canada 3, rec. 3.5; Quebec 4, rec. 2.8, Quebec 5, rec. 26, and Quebec 6 at 60.

109. Queensland 3, rec. B(3)(iii); Victoria 1, s. 25 (unless the minor is married); Spain 1, s. 5.

110. Ontario 1, recs 10 and 11.

111. See, *e.g.*, Spain 1, s. 14, and Spain 2 at 238 (gametes that have been subjected to experimentation cannot be used subsequently for procreation); see also Canada 5 at 43-45, rec. 27.

112. Norway 1, ss 3 and 12, and Sweden 2, s. 2. See also Denmark 1, rec. 7.1a at 125 (minority proposal); Germany 1, s. 1(1)v, does not permit the creation of surplus embryos.

113. Louisiana 2, s. 130; France 5, s. 10 — France 2, L. 671 and L. 676; Quebec 1 at 32-33.

114. Council of Europe 1 at 26-27, and guidelines 11 and 12; Quebec 1, rec. 24 at 39.

115. Victoria 1, s. 13. The couple must have received counselling when they gave their consent to the donation. The minister may also authorize donation if the producers of the gametes are deceased or cannot be located (s. 14).

116. Spain 1, ss 3 and 20, and Spain 3 at 243; Louisiana 2, s. 122; Germany 1, ss 1 and 2; Quebec 6 at 61. See also Denmark 1, rec. 7.1c at 125 (minority proposal).

117. Council of Europe 1 at 24-25 and guideline 8(1); France 5, s. 10 — France 2, L. 669; Quebec 1 at 32, recs 22 and 26, and Quebec 5, rec. 49.

118. Ontario 1, rec. 26.

119. Victoria 1, s. 13; Spain 1, s. 20.

Some jurisdictions are opposed to research on embryos,[120] but most prefer to regulate it. Several types of procedures are prohibited (cloning, use of human gametes with gametes from another species, genetic manipulation, parthenogenesis, ectogenesis[121]), and research must in most cases be approved or authorized by some authority.[122] Experimentation on embryos in vitro is generally permitted only if the objective is therapeutic or preventive,[123] on embryos that do not have the capacity to develop,[124] or if the goal cannot be attained by some other means.[125]

Some countries do not permit experimentation on embryos *in vivo*[126] and prohibit embryos that have been used in research from being implanted in a woman's uterus except to increase the woman's chances of conceiving,[127] or where the experimentation was of a therapeutic nature.[128] Finally, the creation or collection of embryos solely for the purpose of research is often prohibited.[129]

2. Post-Mortem Use of Gametes and Embryos

Post-mortem use of gametes or embryos from a deceased spouse is permitted in some countries.[130] In the United Kingdom, absent a specific provision to that effect in a will,

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120. DENMARK 1, rec. 3.1 at 129 (minority proposal); NORWAY 1, ss 3 and 14; UNITED KINGDOM 5 para. 11.18; QUEBEC 4 at 13, rec. 6.4: the Quebec Status of Women Council recommends a moratorium.

121. See, *e.g.*, NEW SOUTH WALES 4, rec. 13 at 71, and VICTORIA 1, s. 6; DENMARK 1, recs 9.1 and 10.1 at 125-26; SPAIN 1, ss 14, 15 and 20; COUNCIL OF EUROPE 1, guidelines 20 and 21; FRANCE 5, s. 10 — FRANCE 2, L. 673; UNITED KINGDOM 2, s. 3 and appendix 2, s. 3, UNITED KINGDOM 4, preamble and guideline 10, UNITED KINGDOM 5, para. 12.3, recs 15, 47 and 48 at 81 and 85, UNITED KINGDOM 6, paras 37, 39, 41 and 42; GERMANY 1, ss 5 to 7; CANADA 2, rec. 10(f).

122. See, *e.g.*, SOUTH AUSTRALIA 2, s. 14; NEW SOUTH WALES 4, recs 17 to 19; VICTORIA 1, ss 6 and 29; DENMARK 1, rec. 4.1 at 123 and recs 12.1 to 13.2 at 127; SPAIN 1, ss 14 and 15, and SPAIN 2 at 238; COUNCIL OF EUROPE 1, guideline 17(2); FRANCE 5, s. 10 — FRANCE 2, L. 673; UNITED KINGDOM 2, s. 11 and appendix 2, s. 3, UNITED KINGDOM 4, guideline 5, and UNITED KINGDOM 5, paras 11.18 and 12.16, recs 11, 43 and 49 at 81, 84-85; ONTARIO 1, rec. 29; CANADA 2, rec. 10(e), CANADA 5 at 43-45, rec. 27; QUEBEC 6 at 61.

123. See, *e.g.*, SOUTH AUSTRALIA 2, para. 14(2); VICTORIA 1, s. 9A; DENMARK 1, rec. 4.1 at 123; SPAIN 1, ss 12 and 16; COUNCIL OF EUROPE 1, guideline 17(1); ILLINOIS 1, para. 6(7); UNITED KINGDOM 2, appendix 2, s. 3, and UNITED KINGDOM 4, guideline 3; QUEBEC 1 at 33-34, rec. 27.

124. See, *e.g.*, SPAIN 1, s. 15, and SPAIN 2 at 238.

125. See, *e.g.*, DENMARK 1, rec. 4.1 at 123; SPAIN 1, ss 15 and 16; COUNCIL OF EUROPE 1, guideline 17(2); UNITED KINGDOM 4, guideline 2.

126. See, *e.g.*, COUNCIL OF EUROPE 1, guideline 19.

127. See, *e.g.*, NEW SOUTH WALES 4, para. 5.24 and rec. 16; DENMARK 1, rec. 9.1 at 125; COUNCIL OF EUROPE 1, guideline 18; UNITED KINGDOM 4, guideline 4, and UNITED KINGDOM 5, para. 11.22, rec. 46 at 85; QUEBEC 1, rec. 27 at 40.

128. ONTARIO 1, rec. 30; SPAIN 1, ss 12 to 16.

129. See, *e.g.*, DENMARK 1, rec. 9.2 at 126; SPAIN 1, ss 3 and 20; COUNCIL OF EUROPE 1, guideline 16; LOUISIANA 2, s. 122; FRANCE 5, s. 10 — FRANCE 2, L. 669; QUEBEC 1 at 32, and recs 22 and 27 at 39-40. *Contra*: NEW SOUTH WALES 4, rec. 14; VICTORIA 1, s. 9A; UNITED KINGDOM 2, appendix 2, s. 3, and UNITED KINGDOM 5, para. 11.30, rec. 45 at 85. See also GERMANY 1, s. 1(1)v.

130. NEW SOUTH WALES 3, para. 12.4, recs 28 and 29, NEW SOUTH WALES 4, recs 38 and 39; SPAIN 1, s. 9, SPAIN 2 at 237, and SPAIN 3 at 243; UNITED KINGDOM 2, s. 28(6). See also UNITED KINGDOM 5, paras 4.4, 10.9 and 10.15 and UNITED KINGDOM 6, paras 59 and 60, where this practice is discouraged. ONTARIO 1, recs 20 and 21; QUEBEC 5, rec. 35.

the procedure must take place before death for filiation between the child and the deceased spouse to be established.[131] In Spain, filiation between the deceased father and the child is possible only if fertilization occurred within six months of death and the father recognized the unborn child in a will or other notarized document.[132] In Australia, a child conceived by means of AI or IVF after the death of a producer is not entitled to inherit unless a specific bequest is made, but has recourse against the estate under another statute.[133] Finally, the Ontario Law Reform Commission recommends that, absent a specific bequest of course, a child be entitled to inherit as long as the child was conceived before the designation of beneficiaries.[134]

Countries that oppose the post-mortem use of gametes and embryos claim that such use is at odds with the welfare of the child, who would be missing a parent.[135]

E. Parentage

The parentage of children born as a result of gamete or embryo donation is dealt with more frequently than that of children born of a surrogate.[136]

1. Gamete and Embryo Donation

Many countries state that gamete donors are in no way linked through filiation or parental responsibility to children born as a result of their donations.[137] However, some jurisdictions limit the application of this principle to cases where the donation is made

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131. UNITED KINGDOM 2, para. 28(6), UNITED KINGDOM 5, paras 10.9 and 10.15, recs 61 and 64 at 86, and UNITED KINGDOM 6, paras 59, 60 and 88.

132. SPAIN 1, s. 9.

133. NEW SOUTH WALES 1, ss 3 and 5A, NEW SOUTH WALES 3, para. 12.4, recs 28, 29 and 31, and NEW SOUTH WALES 4, rec. 38.

134. ONTARIO 1, recs 20 and 21.

135. DENMARK 1 at 97 and 101, rec. 6.1; COUNCIL OF EUROPE 1 at 24 and guideline 7(4); FRANCE 5, s. 10 and p. 27 — FRANCE 2, L. 668-3; SWEDEN 3 and SWEDEN 4 at 5. See also GERMANY 1, s. 4: para. 4(1): [TRANSLATION] "Anyone will be punished with up to three years imprisonment or a fine, who ... iii knowingly fertilises artificially an egg cell with the sperm of a man after his death." QUEBEC 1 at 21 and rec. 6 at 38, QUEBEC 4 at 12, and QUEBEC 5, rec. 35.

136. See also the section dealing with the post mortem use of gametes and embryos.

137. SOUTH AUSTRALIA 1, s. 10e; WESTERN AUSTRALIA 1, s. 7; NEW SOUTH WALES 1, s. 6; QUEENSLAND 1, ss 15 to 18; TASMANIA 1, s. 10c; NORTHERN TERRITORY 1, ss 5D, 5E and 5F; VICTORIA 2, ss 10c to 10f; DENMARK 1 at 96; SPAIN 3 at 243; COUNCIL OF EUROPE 1 at 28-29 and guideline 14; NEW YORK 1, para. 2(b); MISSOURI 1, s. 210.824; FRANCE 5, s. 11 —FRANCE 3, s. 342-9; NORWAY 1, para. 15(2) (by amendment to the *Children Act*); UNITED KINGDOM 2, s. 28, UNITED KINGDOM 5, paras 4.22, 6.8 and 7.6, recs 52 and 55 at 85, and UNITED KINGDOM 6, para. 88, BRITISH COLUMBIA 1, recs 1 and 13; ONTARIO 1, recs 19(2) and 21; SASKATCHEWAN 1 at 9 and s. 4; CANADA 2 at 14 and rec. 1, and CANADA 5 at 33-34, rec. 18; QUEBEC 1, recs 12 and 13 at 38, QUEBEC 5, recs 24 and 25, QUEBEC 6 at 60, and QUEBEC 7, art. 579.

under medical supervision or through an authorized centre.[138] A recent statute in the United Kingdom provides that the sperm donor must have consented to the donation so as not to be considered the father of the child.[139]

Legal maternity is often established through a presumption that the woman who gives birth to a child is the child's legal mother.[140] The Ontario Law Reform Commission recommends that the woman who carries the child with the intent of raising it be recognized conclusively as the mother.[141] Spanish law provides that married couples who consent to the procedure cannot challenge maternal filiation.[142]

The husband of the woman who gives birth to the child is recognized as the child's legal father, either by presumption or as a result of his consent to the procedure,[143] which consent is presumed until proven otherwise in many countries.[144] Finally, according to the Law Reform Commission of Saskatchewan, consent could be given before or after insemination.[145]

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138. In Europe, where the donation is not made through an authorized centre, the donor retains parental obligations and a filial relationship with the child may be established: COUNCIL OF EUROPE 1 at 29, guideline 14(3). See also SASKATCHEWAN 1, ss 2 and 4.

139. UNITED KINGDOM 2, para. 28(6).

140. COMMONWEALTH OF AUSTRALIA 1, s. 60B; SOUTH AUSTRALIA 1, s. 10c; WESTERN AUSTRALIA 1, ss 5 and 7; NEW SOUTH WALES 4, rec. 37; QUEENSLAND 1, s. 17; TASMANIA 1, s. 10c; NORTHERN TERRITORY 1, s. 5C; VICTORIA 2, s. 10E; SPAIN 3 at 242; COUNCIL OF EUROPE 1 at 28-29, guideline 14; ARKANSAS 1, s. 9-10-201; UNITED KINGDOM 2, s. 27, UNITED KINGDOM 5, paras 6.8 and 7.6, recs 55 and 56 at 85-86, and UNITED KINGDOM 6, para. 88; CANADA 2, rec. 2; QUEBEC 1, recs 13 at 38, and QUEBEC 5, rec. 34.

141. ONTARIO 1, rec. 19(1).

142. SPAIN 1, s. 8.

143. COMMONWEALTH OF AUSTRALIA 1, s. 60B; SOUTH AUSTRALIA 1, s. 10d; WESTERN AUSTRALIA 1, s. 6; NEW SOUTH WALES 1, s. 5; QUEENSLAND 1, ss 15 to 17; TASMANIA 1, s. 10c; NORTHERN TERRITORY 1, s. 5D; VICTORIA 2, ss 10C to 10E; SPAIN 3 at 242; COUNCIL OF EUROPE 1 at 29, guideline 14(2); NEW YORK 1, s. 1; MISSOURI 1, s. 210.824; ARKANSAS 1, s. 9-10-201; FRANCE 5 at 29 (in accordance with ordinary law, FRANCE 3, s. 312); NORWAY 1, para. 15(2) (by amendment to s. 9 of the *Children Act*); UNITED KINGDOM 2, s. 28, UNITED KINGDOM 5, paras 4.17, 4.24, 4.25 and 7.6, recs 51, 54 and 56 at 85-86, and UNITED KINGDOM 6, paras 88 and 89; BRITISH COLUMBIA 1, recs 1 and 17; CANADA 3, rec. 1; ONTARIO 1, rec. 19(1); SASKATCHEWAN 1 at 8 and ss 2(a) and 3; CANADA 2, rec. 3; QUEBEC 1 at 25 and recs 11 and 12 at 38, QUEBEC 5, rec. 33, and QUEBEC 7, arts 580 and 581. SWEDEN and some 30 American states have adopted similar legislation, based on the *Uniform Parentage Act* (see UNITED STATES 5 at 244).

144. COMMONWEALTH OF AUSTRALIA 1, s. 60B; SOUTH AUSTRALIA 1, ss 10a and 10d; WESTERN AUSTRALIA 1, ss 3, 5 and 6; NEW SOUTH WALES 1, ss 3 and 5; QUEENSLAND 1, ss 13 and 15 to 17; TASMANIA 1, s. 10c; NORTHERN TERRITORY 1, ss 5A and 5D; VICTORIA 2, ss 10A, 10C, 10D and 10E; UNITED KINGDOM 5, para. 4.24, rec. 54 at 85, and UNITED KINGDOM 6, paras 88 and 89 (proposed amendment to the *Family Law Reform Act* 1987, to include ovum and embryo donations); ONTARIO 1, rec. 19(3); and CANADA 2, rec. 3.

145. SASKATCHEWAN 1 at 8 and s. 3.

In most countries, if the couple is not married the *de facto* husband can generally be recognized as the father of the child if he consented to the procedure.[146] According to the Ontario Law Reform Commission's proposal, the husband or partner of a woman who carries a child with the intention of raising it would be deemed conclusively, if he consented, to be the child's legal father.[147]

Disavowal or contestation of paternity is normally carried out by proving the absence of consent or the fact that the child was born naturally, not as a result of a technology.[148] In France, a partner who consented but no longer recognizes the child once the child is born remains responsible to the mother and child. Further, it is impossible for anyone, the child included, to challenge this filiation on the grounds that there is no biological link.[149]

A child born as a result of medically assisted procreation has the same rights as a legitimate child or a child conceived naturally if the couple that used the technologies is married and the husband gave his consent.[150] Some countries specify that insemination must have been performed under medical supervision,[151] while others require that the birth certificate give no indication as to the method of conception.[152]

2. Surrogacy

Many countries that attempt to discourage surrogate motherhood recommend that the presumption attributing legal maternity to the woman who gives birth be applied to surrogacy contracts.[153] Spanish law does not allow a woman to enter into a contract in advance in order to renounce her maternal filiation.[154] The report of the Barreau du Québec states that no preferential right of adoption should be granted to the spouse of

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146. COMMONWEALTH OF AUSTRALIA 1, s. 60B; SOUTH AUSTRALIA 1, ss 10a and 10d; WESTERN AUSTRALIA 1, ss 3, 5 and 6; NEW SOUTH WALES 1, ss 3 and 5; QUEENSLAND 1, ss 13 and 15 to 17; NORTHERN TERRITORY 1, ss 5A and 5D; VICTORIA 2, ss 10A, 10C to 10E; SPAIN 1, s. 6, and SPAIN 3 at 242; COUNCIL OF EUROPE 1, guideline 14(2); UNITED KINGDOM 2, s. 28; CANADA 2, rec. 3; QUEBEC 5, rec. 34, and QUEBEC 7, art. 581.

147. ONTARIO 1, rec. 19(1).

148. COUNCIL OF EUROPE 1 at 29, guideline 14(2); LOUISIANA 1, s. 188; UNITED KINGDOM 5, para. 4.24, rec. 53 at 85; ONTARIO 1, rec. 19(3); QUEBEC 7, art. 580.

149. FRANCE 5, s. 11 and pp. 29-30; FRANCE 3, ss 342-10 and 342-11.

150. COUNCIL OF EUROPE 1 at 28-29; ARKANSAS 1, s. 9-10-201; FRANCE 5 at 29 (legitimate child of husband, FRANCE 3, art. 312); NORWAY 1, para. 15(2); UNITED KINGDOM 5, paras 4.17, 4.24 and 7.6, recs 51, 53 and 56 at 85-86, and UNITED KINGDOM 6, para. 89; BRITISH COLUMBIA 1, rec. 1; CANADA 3 at 33-34 and rec. 1; ONTARIO 1, rec. 21; SASKATCHEWAN 1, s. 3.

151. NEW YORK 1, s. 1; SASKATCHEWAN 1, ss 2(a) and (b).

152. NEW SOUTH WALES 3, paras 11.1 to 11.4, NEW SOUTH WALES 4, rec. 41 at 104; COMMONWEALTH OF AUSTRALIA 2, rec. X; SPAIN 1, s. 7; FRANCE 5 at 29; BRITISH COLUMBIA 1, rec. 17; ONTARIO 1, rec. 20; CANADA 2 at 16, rec. 4. See, however, UNITED KINGDOM 5, paras 4.25, 6.8 and 7.6, and UNITED KINGDOM 6, para. 90, which do not seem to reject recording the method of conception in birth records.

153. NEW SOUTH WALES 5, rec. 9 at 60-62; COUNCIL OF EUROPE 1 at 28-29 and guideline 14; SPAIN 1, s. 10; UNITED KINGDOM 2, s. 27, and UNITED KINGDOM 5, para. 8.20.

154. SPAIN 1, s. 10, SPAIN 2 at 237, and SPAIN 3 at 242.

the biological father.[155] In the United Kingdom, the Interim Licensing Authority recommends that surrogacy by IVF between close relatives be avoided.[156] Finally, some organizations would grant children born as result of this practice the same rights of access to information as adopted children or children born as a result of artificial insemination.[157]

In Arkansas, the biological father and his wife are recognized as the parents of a child born under a surrogacy contract, although the surrogate's name is recorded on the birth certificate.[158] In Michigan, when a dispute arises, the party with physical custody of the child keeps the child until a court, basing its decision on the best interests of the child, determines otherwise.[159]

The report of the Canadian Bar Association, which does not oppose unchallenged gratuitous agreements, recommends that adoption and family laws be amended to facilitate recognition of the social parents as the legal parents in this specific case. No visitation or custody rights would be granted if the surrogate mother refuses to turn the child over, and the surrogate may, if she keeps the child, claim child support from the couple who refuses to adopt.[160] The position and recommendations of the New York Task Force on Life and the Law are similar: in the event of a dispute arising in the performance of a gratuitous agreement, the court must award custody to the surrogate unless there is clear, convincing evidence that the interest of the child would be better served by a different order.[161]

The Ontario Law Reform Commission favours regulating contracts by proposing that maternal and paternal filiation revert to the applicant couple as soon as the child is born. The surrogate could not change her mind; she must turn the child over at that time, if necessary under a court order.[162]

II. Safety of Medically Assisted Procreation Technologies

Practical standards, record keeping and access to information, as well as donor liability and remedies available to the child, are some of the issues addressed by the legislation and reports surveyed, in the context of ensuring the safety of medically assisted procreation.

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155. QUEBEC 1 at 29-30 and rec. 21 at 39. See also NEW SOUTH WALES 5, rec. 10 at 62-65.

156. UNITED KINGDOM 4, guideline 13(k). See also QUEBEC 5, rec. 58, which opposes the practice of surrogacy contracts with embryo transfer.

157. NEW SOUTH WALES 5, rec. 11; QUEBEC 4 at 20.

158. ARKANSAS 1, s. 9-10-201.

159. MICHIGAN 1, s. 722.861, section 11.

160. CANADA 2 at 26-33 and recs 9(c) to 9(h); the surrogate would have the same time as in the case of adoption to decide if she wants to keep the child.

161. NEW YORK 2 at 136-37, and s. 4 of the *Proposed Surrogate Parenting Act*. The court must also determine visiting rights and child support in relation to the current law. The burden of proof respecting the interests of the child is greater than the preponderance of evidence but less than proof beyond all reasonable doubt.

162. ONTARIO 1, recs 49 and 56 to 59. See also NEW YORK 2 at 99, which cites the Florida bill prohibiting surrogates from revoking their consent to adoption.

A. Practical Standards

Physical risks, limits on the frequency of use of gametes from a single donor and consultation are areas in which standards are often proposed.

1. Physical Risks

To ensure the quality of gametes, the reports recommend that the following measures be mandatory: psychological assessment of the donor and his or her motivation,[163] medical examination of the donor,[164] screening for transmissible or hereditary diseases,[165] genetic screening or family history assessment,[166] blood tests for HIV (human immunodeficiency virus) antibodies,[167] or repetition of HIV screening of the donor at least six months after the donation, before the sperm is used for any purpose.[168]

Some countries require, or at least recommend, that only frozen sperm be used,[169] while others feel it is sufficient to follow the guidelines of the medical profession on the screening and selection of donors.[170]

As to recommendations on the storage of gametes and embryos, the maximum period for storing gametes usually ranges from five to ten years.[171] The freezing of unfertilized

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163. British Columbia 1, rec. 10; Canada 3 at 5, and Canada 4 at 6; Quebec 5, rec. 14.

164. Delaware 1, s. 2801; Ohio 1, s. 3111.33; United States 1, guideline VII, and United States 2 at 45S; United Kingdom 5, para. 4.18; British Columbia 1, rec. 11; Canada 3 at 9-10, Canada 4 at 5, and Canada 5 at 29-30, rec. 12: "The Societies recommend that donors be required to pass genetic and medical screening tests as set by the professional society."

165. Spain 1, s. 5; Council of Europe 1, guideline 5; Ohio 1, s. 3111.33; United Kingdom 5, para. 4.18; Sweden 3; British Columbia 1, rec. 11; Canada 3, rec. 2, and Canada 4 at 5.

166. New South Wales 3, paras 5.12 and 5.15; Queensland 3 at 111; Spain 1, s. 5; Council of Europe 1, guideline 5; United States 1, guideline VII, United States 2 at 45S, and Ohio 1, s. 3111.33; British Columbia 1, rec. 11; Canada 3 at 7-9, rec. 2.2, and Canada 4 at 5-6. See also Quebec 1 at 23, which recommends the adoption of minimum uniform standards for selecting and matching donors.

167. United States 1, guidelines V, VI and VII; United Kingdom 4, guideline 13(h); Sweden 3; Canada 1 at 27, and Canada 4 at 5; Canada 5 at 38-39, rec. 22; Quebec 1 at 23; Quebec 5, rec. 17, and Quebec 6 at 61. The United States and the United Kingdom also recommend screening for hepatitis B.

168. Louisiana 4, s. 1062.1; United States 1, guideline VII; Sweden 3; Canada 4 at 5; Quebec 4 at 13 and rec. 2.7, Quebec 5 at 89-92 and rec. 17, and Quebec 6 at 43-45.

169. Denmark 1 at 97; United States 1, guideline VII(D), United States 2 at 44S; Louisiana 4, s. 1062.1 (except for AIH); United Kingdom 4, guideline 13(i), United Kingdom 5, para. 10.1 and rec. 30 at 83 (except for AIH), and United Kingdom 6, para. 44; Sweden 3; Canada 4 at 5, Canada 5 at 38-39, rec. 22; Quebec 4 at 13 and rec. 2.7, Quebec 5, rec. 17, and Quebec 6 at 61.

170. New South Wales 3, paras 5.12 and 9.11, recs 4, 17 and 18; United Kingdom 5, para. 4.5 (for AIH); Ontario 1, rec. 8 (recommends national consultation, however, to ensure uniformity); Saskatchewan 1 at 3; Canada 2 at 19 (provincial gamete banks would ensure quality of gametes and select donors).

171. Spain 1, s. 11; Council of Europe 1, guidelines 7(2) and 7(3); France 5, s. 10 and p. 23 — France 2, L. 668-3; United Kingdom 2, s. 14, United Kingdom 5, para. 10.8 and rec. 31 at 83, and United Kingdom 6, para. 54. See also Quebec 1, rec. 9 at 38. The reader will find in table 3, *infra* at 206-209, a list of proposed time limits.

eggs is often discouraged.[172] The recommended period for storing embryos ranges from twelve months to ten years,[173] and eggs fertilized in vitro may not be kept for more than fourteen days.[174]

The risks associated with multiple pregnancy, the number of embryos to be implanted and their subsequent reduction have been the subject of some commentary.[175] Further, embryo donation or transfer from one woman's uterus to another's (whether by uterine lavage or any other method) is generally discouraged because of its experimental nature and the risk of pregnancy for the donor.[176]

2. The Frequency of Use of Gametes from a Single Donor

Controlling the number of times gametes from the same donor may be used has been recommended, by restricting either the number of uses or the number of children resulting from the gametes.[177] The objective is to prevent the risk of consanguinity and the

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172. Spain 1, s. 11; United States 2 at 57S; Norway 1, s. 3; United Kingdom 4, guideline 11 (ovum freezing is permitted, but subsequent implantation is prohibited), and United Kingdom 5, para. 10.2 and rec. 9 at 81; Quebec 5, rec. 52.

173. South Australia 2, paras 10(3) and 13(6); New South Wales 4, rec. 2 at 55-56, and rec. 22 at 86; Denmark 1, rec. 6.1 at 124; Spain 1, s. 11; Council of Europe 1, guideline 8(2); France 5, s. 10 — France 2, L. 670; Norway 1, s. 3; United Kingdom 2, s. 14, United Kingdom 4, guideline 8, United Kingdom 5, para. 10.10, rec. 32 at 83, and United Kingdom 6, para. 54; Ontario 1, rec. 32; Canada 2, rec. 10(g); Quebec 1 at 32-34, Quebec 5, rec. 46.

174. South Australia 2, paras 10(3) and 13(6) (the freezing period may not go beyond the point where the embryo would normally be implanted); New South Wales 4, rec. 2 at 55-56 and rec. 15 at 72; Spain 1, ss 15 and 20; Council of Europe 1, guideline 17(2)b); France 5, s. 10 — France 2, L. 672 (seven-day period); United Kingdom 2, s. 3, United Kingdom 4, guidelines 7 and 8, United Kingdom 5, para. 11.22, recs 12 and 45 at 81 and 85, and United Kingdom 6, paras 33 and 34; Ontario 1, rec. 31; Canada 2, rec. 10(c); Quebec 1, rec. 27 at 39-40.

175. Denmark 1 at 100: reduction is permitted if medical circumstances so require; Spain 1, s. 4: embryos are implanted in numbers deemed sufficient for reasonable chances of pregnancy; United Kingdom 4, guideline 12: the number of embryos to be implanted is limited to three; United Kingdom 5, para. 5.4: the number of embryos to be implanted is left to the judgment of the physician; Germany 1, s. 1: the number of embryos to be implanted is limited to three; Ontario 1, rec. 26: no restriction on the number of embryos to be implanted should be imposed; Quebec 5, recs 42 and 43, which accepts implantation of several embryos, but is opposed to reduction.

176. South Australia 2, paras 10(3) and 13(6); Council of Europe 1 at 27, guideline 12; United States 2 at 54S; Spain 1, s. 20; France 5, s. 10 — France 2, L. 669; United Kingdom 5, para. 7.5 and rec. 8 at 81; Germany 1, s. 1; Canada 5 at 24, rec. 8; Quebec 1 at 19 and rec. 4 at 38. *Contra*: Ontario 1 at 146 and rec. 1.

177. Spain 1, s. 5; United States 1, guideline VII(C), and United States 2 at 45S; United Kingdom 5, paras 4.26 and 6.6, recs 23 and 27 at 82-83; British Columbia 1, rec. 12; Quebec 4 at 13, rec. 2.4, and Quebec 5, rec. 22. The following reports recommend a limit but do not set a figure: New South Wales 3, para. 9.15, recs 20 and 21; Denmark 1, reg. 3.1 at 132 (to be determined by the Danish Board of Health); Council of Europe 1, guideline 10; France 5, s. 10 — France 2, L. 668-9 (to be set by order of the Minister of Health); United Kingdom 6, para. 87; Canada 3 at 12 and rec. 2.4; Quebec 1 at 24.

transmission of diseases that current medical expertise does not make it possible to detect.[178] Moreover, the Ontario report proposes to leave the number of times gametes from the same donor may be used to be determined on the basis of the physician's judgment and the wishes of the parties.[179]

3. Counselling

To assist the parties involved in medically assisted procreation programs, counselling is recommended in some countries[180] and mandatory in others.[181] For example, legislation in the state of Victoria makes counselling mandatory before any procedure, including gamete donation.[182]

B. Record Keeping and Access to Information

Record keeping and centralization of information, as well as access to information, have been the subject of numerous recommendations.

1. Record Keeping and Centralization of Information

All jurisdictions agree on the need to keep records, but there are differing opinions as to how they should be kept. Responsibility for keeping records may rest with the physician or the clinic,[183] and in most cases a system that allows the donor's file to be linked with

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178. See, *e.g.*, COUNCIL OF EUROPE 1 at 25-26.

179. ONTARIO 1, rec. 16.

180. NEW SOUTH WALES 3, para. 7.11, rec. 13; NEW SOUTH WALES 4, rec. 10 at 67-68; COMMONWEALTH OF AUSTRALIA 2, rec. VII; DENMARK 1 at 99; UNITED STATES 1, guideline IV, and UNITED STATES 2 at 47S and 60S; UNITED KINGDOM 2, para. 13(6) and appendix 3, s. 3, UNITED KINGDOM 4, guidelines 13(g) and 15(a), UNITED KINGDOM 5, paras 3.4, 6.6 and 7.7, recs 19 and 27 at 82-83, and UNITED KINGDOM 6, paras 56, 60 and 77; BRITISH COLUMBIA 1 at 10 and rec. 10; CANADA 1 at 26-27, CANADA 3 at 26 and rec. 3.3, and CANADA 4 at 6; QUEBEC 1 at 24 and rec. 5 at 38, QUEBEC 4 at 10, recs 1.5, 2.3, 2.5 and 3.1, and QUEBEC 5 at 58, rec. 36.

181. VICTORIA 1, ss 9 to 13A, 18; SPAIN 1, s. 2; COUNCIL OF EUROPE 1, guideline 4(2).

182. VICTORIA 1, ss 9 to 13A, 18. The counsellor must be approved by the minister. The physician conducting the procedure must ensure that the couple, not just the person undergoing the procedure, have received counselling and that follow-up is arranged.

183. SOUTH AUSTRALIA 2, paras 13(3) and (6) (physician); NEW SOUTH WALES 1, s. 16 (physician), NEW SOUTH WALES 3, para. 13.30 and rec. 37 (physician and clinic), and NEW SOUTH WALES 4, recs 27 to 29 at 90-92 (clinic); COUNCIL OF EUROPE 1, guideline 6 (physician and clinic); SPAIN 1, s. 19 (physician); UNITED STATES 2 at 44S and 76S (physician); UNITED KINGDOM 4, guidelines 13(b) and 14(b) (clinic); CANADA 3 at 23-24 (physician).

the recipient's but still protects anonymity is recommended.[184] One Australian report recommends that when a child is born as a result of a gamete or embryo donation, records be kept indefinitely.[185]

It is often recommended that a central registry containing the records of donors and children born as a result of medically assisted procreation be established and that physicians and clinics be required to report to this registry.[186] However, there are fears about the risk to anonymity that could result from such a registry.[187]

2. Access to Information

The anonymity of the donor and the parties is a general rule followed by all countries except Sweden,[188] where donor anonymity has given way to the fundamental right of children to know about their genetic origins.[189] Some state that information obtained from donors enjoys the same guarantee of confidentiality as information obtained from patients,[190] and the terms applicable to consent by the parties to the conditions governing access to information are in some cases addressed.[191]

The terms of access to information differ depending on whether the information is identifying or not. Conditions that warrant disclosure of identity vary: if the person

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184. UNITED STATES 2 at 76S; OHIO 1, s. 3111.36; SWEDEN 3; BRITISH COLUMBIA 1, rec. 16; CANADA 3 at 18-25, rec. 3.2; ONTARIO 1, recs 22(3) and 22(5); QUEBEC 5, rec. 24, and QUEBEC 6 at 60.

185. COMMONWEALTH OF AUSTRALIA 2, rec. II. See also SWEDEN 1, s. 3, and SWEDEN 3: records are kept for 70 years.

186. VICTORIA 1, s. 22; QUEENSLAND 3, recs B(3) (xi) and B(3) (xii); COMMONWEALTH OF AUSTRALIA 2, recs IV and VIII; SPAIN 1, s. 5; PENNSYLVANIA 1, s. 3213; UNITED KINGDOM 2, s. 31, UNITED KINGDOM 4, guideline 13(b), UNITED KINGDOM 5, para. 13.9, rec. 16 at 81, and UNITED KINGDOM 6, paras 15, 79, 80 and 85; CANADA 1 at 27, and CANADA 2 at 24-25, rec. 5; QUEBEC 4 at 25.

187. NEW SOUTH WALES 3, para. 13.30, rec. 37, and NEW SOUTH WALES 4, para. 5.52; CANADA 3 at 23.

188. NEW SOUTH WALES 1, s. 14, NEW SOUTH WALES 3, paras 8.2 and 8.13, recs 14 and 16, and NEW SOUTH WALES 4, rec. 34 at 97; QUEENSLAND 3, rec. B(3) (xiii); VICTORIA 1, s. 23; COMMONWEALTH OF AUSTRALIA 2, rec. I; DENMARK 1, rec. 8.1 at 125 and reg. 5.1 at 133; SPAIN 1, ss 2, 5, 19 and 20; COUNCIL OF EUROPE 1, guideline 13; UNITED STATES 1, guideline VII(c), and UNITED STATES 2 at 44S, 50S, 52S, 75S and 76S; FRANCE 5, s. 10 — FRANCE 2, L. 668-8, and FRANCE 4, s. 378; NORWAY 1, s. 10; UNITED KINGDOM 2, ss 31 to 33 and s. 41, UNITED KINGDOM 4, guideline 13(j), UNITED KINGDOM 5, paras 3.2, 6.6 and 7.7, recs 18 and 27 at 82-83, and UNITED KINGDOM 6, paras 83 and 84; BRITISH COLUMBIA 1, recs 1 and 9; ONTARIO 1, rec. 22(4); SASKATCHEWAN 1 at 10 and s. 5(1); CANADA 2 at 24, and CANADA 4 at 10; QUEBEC 1, recs 15 and 16 at 38-39, QUEBEC 5, recs 29 and 31, and QUEBEC 7, art. 583.

189. SWEDEN 1, s. 4, and SWEDEN 5 at 389: the child has a right of access to the donor's complete file when he is deemed sufficiently mature. See also DENMARK 1, rec. 8.1a at 125, and reg. 5.1a at 132, where a minority of the members shared this view in cases of gamete or embryo donation.

190. NEW SOUTH WALES 1, s. 14, NEW SOUTH WALES 3, paras 8.13 and 14.10, and NEW SOUTH WALES 4, rec. 34 at 97; ONTARIO 1, rec. 22(2).

191. See, *e.g.*, COMMONWEALTH OF AUSTRALIA 2, rec. VII: the parties must give their formal consent to the conditions of access to information before any procedure. QUEBEC 6 at 60: the donor must be informed of the type of information to which the child may have access; see also SWEDEN 3.

consents;[192] if there is reasonable cause or in extreme cases;[193] pursuant to a ruling by a specific authority;[194] if there is a risk to life or health;[195] as part of the requirements of the agency that performs the technologies or conducts research; and finally, in connection with enforcement of the law.[196] Further, anonymity could be removed in the future in circumstances that have yet to be determined.[197] Others already grant children who have reached the age of majority access to identifying data on request.[198]

Children may be granted access to non-identifying information in donors' files when they reach the age of 18,[199] when they reach the age of 14,[200] or regardless of their age.[201]

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192. SOUTH AUSTRALIA 2, s. 18; NEW SOUTH WALES 1, s. 15 (the right of access is denied to children under 18 years of age, unless they are married), NEW SOUTH WALES 3, paras 8.2 and 13.23, recs 15 and 32, and NEW SOUTH WALES 4, rec. 31 at 92-93; VICTORIA 1, s. 22; COMMONWEALTH OF AUSTRALIA 2, rec. VII, option 2 (the right of access may be exercised only where the child is 18, by written request from a person with a legitimate interest, and the parents must consent if the information requested concerns the child); CANADA 5 at 35-37, recs 19 to 21; QUEBEC 5, recs 31 and 32 (the donor has a right to refuse the disclosure of his or her identity, and the parents may refuse on behalf of the child if he or she is unaware of the method of his or her conception).

193. COMMONWEALTH OF AUSTRALIA 2, rec. VII; UNITED STATES 2 at 44S; QUEBEC 1, recs 14 to 16 at 38-39.

194. NEW SOUTH WALES 1, s. 15, NEW SOUTH WALES 3, para. 8.2, rec.15, and NEW SOUTH WALES 4, rec. 31 at 92-93 (on permission of the biomedical council); COMMONWEALTH OF AUSTRALIA 2, rec. VII; SPAIN 2 at 237 (in the context of legal proceedings); SWEDEN 1, s. 5 (in the context of legal proceedings where paternity is in dispute); CANADA 2, rec. 6 (court order allowing access to provincial registry); QUEBEC 5, recs 29 and 32 (access to physician and donor allowed where medical reasons so require, or court order).

195. SPAIN 1, ss 5 and 8 (proven danger to the life of the child; however, the disclosure of identity does not prove legal paternity); CANADA 2, rec. 6 (access to provincial registry would be allowed only in cases of medical necessity); CANADA 3 at 27 (congenital or hereditary disease of the child where this information affects the donor's health); SASKATCHEWAN 1 at 12 and s. 5 (for AID, the information may be consulted by physicians and medical staff or under their supervision; the information is admissible as evidence in legal proceedings provided that the identity of the donor is not revealed); QUEBEC 1 at 27, and recs 15 and 16 at 38-39 (on permission of the court, if to save human life or prevent major psychological problems in the child; however, direct contact is not mandatory); QUEBEC 5, recs 29 and 32 (access to physician and donor allowed if necessary for medical reasons), and QUEBEC 7, art. 583.

196. SOUTH AUSTRALIA 2, s. 18; NEW SOUTH WALES 1, s. 15, NEW SOUTH WALES 3, para. 8.2, rec.15, and NEW SOUTH WALES 4, rec. 31 at 92-93.

197. COUNCIL OF EUROPE 1, guideline 13 (member states may adopt legislation permitting access to the donor's identity and the method of conception); UNITED KINGDOM 6, para. 84; QUEBEC 6 at 60-61; VICTORIA 4, paras 3.14 and 3.36; NEW SOUTH WALES 4, rec. 32 at 95.

198. COMMONWEALTH OF AUSTRALIA 2, rec. VII, option I; UNITED KINGDOM 2, s. 31; QUEBEC 4 at 13 and rec. 2.9. For more details, see QUEBEC 2.

199. NEW SOUTH WALES 5, rec. 11 at 66-67; UNITED KINGDOM 5, paras 4.21, 6.6 and 7.7, recs 20 and 27 at 82-83, and UNITED KINGDOM 6, para. 83. See also SPAIN 1, ss 5 and 19.

200. QUEBEC 4 at 13 and rec. 2.5; QUEBEC 5, rec. 28.

201. NEW SOUTH WALES 1, s. 17 (a person having "good cause" based on welfare of health of a party may have access to the information upon simple agreement with the holder of the records), NEW SOUTH WALES 3, para. 13.23 and rec. 33, and NEW SOUTH WALES 4, recs 30, 32 and 33 at 92-95 (the information may be disclosed to the child, the donor or any person providing evidence of a "good cause" or pursuant to a decision by the biomedical council); VICTORIA 1, ss 20 and 23 and appendix 7; COMMONWEALTH OF AUSTRALIA 2, rec. VII (written request to state registry by a person with legitimate interest or by the parents of the child if the child is a minor); UNITED STATES 1, guideline VII(c), and UNITED STATES 2 at 44S; UNITED KINGDOM 2, s. 31 (the information that may be disclosed to a minor is limited to the existence of a genetic link with potential spouse; counselling must be offered); ONTARIO 1, rec. 22(7) (the issue would be left to the discretion of the attending physician); CANADA 5 at 35-37, recs 19 to 21; QUEBEC 6 at 60.

However, some require a medical reason, such as the discovery of a genetic or hereditary disease.[202] Finally, it is sometimes stated that the decision to tell the child about his or her origins is a private matter.[203]

C. Liability of Donors and Remedies Available to Children

In some countries, donors who intentionally conceal necessary information or give false information are guilty of an offence.[204] However, France's draft bill states that donors have no liability *vis-à-vis* the child.[205]

With respect to civil remedies, the creation of a specific remedy for children who have sustained injury is generally not recommended because the physician continues to be subject to the rules of tort law.[206]

Finally, it should be noted that the report to the Minister of National Health and Welfare looks at the possibility of creating an agency to review any court actions resulting from the birth of a child with a congenital deformity or serious genetic disease.[207]

III. Medical Control and Regulation

Uniform state, provincial or national legislation or regulations are recommended in a number of jurisdictions,[208] while others prefer to leave some matters to the professional

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202. COUNCIL OF EUROPE 1, guideline 13; BRITISH COLUMBIA 1, rec. 16.

203. See, *e.g.*, COMMONWEALTH OF AUSTRALIA 2, rec. I; CANADA 3 at 26, and ONTARIO 1, rec. 22(7); QUEBEC 5, rec. 24.

204. NEW SOUTH WALES 1, s. 11, NEW SOUTH WALES 3, para. 5.18, rec. 5, and NEW SOUTH WALES 4, rec. 35 at 98; VICTORIA 1, s. 27; ONTARIO 1, rec. 23. See also UNITED STATES 2 at 24S (moral duty rather than offence); CANADA 3 at 23 (protection of donor anonymity is conditional on donor disclosing genetic and medical information that to the best of his or her knowledge is accurate).

205. FRANCE 5, s. 11 — FRANCE 3, s. 342-9.

206. NEW SOUTH WALES 3, para. 14.9, rec. 41, and NEW SOUTH WALES 4, rec. 11 at 69; SPAIN 1, s. 19; BRITISH COLUMBIA 1, recs 1 and 15; ONTARIO 1, recs 22, 24 and 25; SASKATCHEWAN 1 at 4-5.

207. CANADA 3 at 22.

208. See, *e.g.*, NEW SOUTH WALES 3, para. 5.12, rec. 4 (recruitment and screening of donors); ONTARIO 1, rec. 9 (recruitment and screening of donors); CANADA 3, rec. 2 and p. 15 (acquisition, storage and import of human sperm); CANADA 2, rec. 10(e) (research); CANADA 5 at 39, rec. 23: "The Societies endorse the facilities for the screening, storage and ultimate disposition of frozen donor sperm. Such facilities should be *required by law* to adhere to standards as provided by professional societies such as CFAS for the medical/genetic screening of donors, screening of semen for STD and record keeping." [emphasis added]; QUEBEC 1, rec. 2 at 37.

judgment of physicians,[209] ethics committees[210] and working groups.[211] It has also been recommended that some issues be studied,[212] but most recommendations deal with medical control and regulation of technologies.

A. Medical Control

There is a definite need for medical control of medically assisted procreation. Legislation provides that the technologies are to be performed by physicians or specialists or under their supervision, or in hospitals or authorized centres.[213] The reports require the medical supervision or intervention of a physician, on the ground that medically assisted procreation technologies are a part of medical practice[214] and, as such, must be carried out in authorized centres or clinics.[215]

With respect to the storage, transfer and import of gametes and embryos, British Columbia recommends the creation of a government-controlled institutional sperm

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209. See, *e.g.*, NEW SOUTH WALES 3, recs 7, 12, 17 and 36 (consent forms, counselling, screening tests, record keeping); UNITED STATES 2 at 75S-80S; ONTARIO 1, recs 16 and 24 (frequency of use of gametes from a single donor and access to non-identifying information); SASKATCHEWAN 1 at 3.

210. See, *e.g.*, NEW SOUTH WALES 4, recs 1, 2 and 21 and paras 5.9 to 5.11 (code of ethics for storage and utilization of embryos created by IVF); UNITED STATES 2 at 77S; UNITED KINGDOM 4, guidelines 13(a) and 14(a) (every centre must have access to a multidisciplinary ethics committee that includes women to approve the technologies used); SWEDEN 5 at 389 (research and experimentation).

211. See, *e.g.*, UNITED KINGDOM 5, para. 2.17 and rec. 38 at 84 (national working group made up of health services representatives and practitioners to establish guidelines for organization of services); QUEBEC 5, recs 60 and 61 (multidisciplinary task force to study embryo research and suggest guidelines to Minister of Health).

212. See, *e.g.*, UNITED STATES 2 at 75S (long-term impact on patients); CANADA 1 at 27-28 (infertility, impact of mutagenic factors, origins of male factor infertility, screening programs for chlamydia and gonorrhea), and CANADA 3, rec. 2.5 (long-term effects of donor selection criteria); QUEBEC 5, recs 6, 19 and 44 (causes of and treatments for infertility, contraceptives, alternatives to early voluntary sterilization, improvement of success rates with frozen sperm, risks of multiple pregnancy in relation to number of embryos implanted, improvement of chances of pregnancy with only one embryo transferred); QUEBEC 6 at 60 (infertility, fertility, contraceptives, alternatives to early sterilization).

213. SOUTH AUSTRALIA 2, s. 13; NEW SOUTH WALES 1; VICTORIA 1, ss 7, 9 to 13A and 17; SPAIN 1, ss 18 to 20; LOUISIANA 2, s. 128; OHIO 1, s. 3111.32; FRANCE 1, s. 2; NORWAY 1, ss 2 and 14; SWEDEN 1, s. 3, SWEDEN 2, ss 3 and 4, and SWEDEN 5 at 388-89; GERMANY 1, ss 9, 11 and 12.

214. NEW SOUTH WALES 3, para. 4.7, rec. 2, and NEW SOUTH WALES 4, rec. 5 at 62; DENMARK 1 at 97 and 99; COUNCIL OF EUROPE 1 at 20-21 and guideline 2; UNITED STATES 2 at 75S-77S; FRANCE 5, s. 10 — FRANCE 2, L. 668-2 and L. 675; UNITED KINGDOM 5, paras 3.1, 4.5 and 13.7, rec. 3 at 80; BRITISH COLUMBIA 1, rec. 6; ONTARIO 1, rec. 3; CANADA 2 at 17-18 and rec. 7.

215. SOUTH AUSTRALIA 3, rec. 7; NEW SOUTH WALES 3, paras 4.6 and 4.7, recs 1 and 2, and NEW SOUTH WALES 4, recs 1, 4 and 6; QUEENSLAND 3, rec. B(1) (iii); DENMARK 1 at 97 and 99; COUNCIL OF EUROPE 1 at 20-21 and guideline 2; FRANCE 5, s. 10 — FRANCE 2, L. 668-2 and L. 675 (for IVF and embryo transfer); UNITED KINGDOM 5, paras 4.16, 5.10, 6.6, 7.4 and 13.7, recs 3 to 7 at 80, and UNITED KINGDOM 6, paras 15, 20, 21 and 27 (for AID, IVF, ovum donation and embryo transfer); QUEBEC 4 at 13, recs 2.2 and 6.2, QUEBEC 5, recs 8, 9, 36, 37 and 64, and QUEBEC 6 at 60 (limit on number of centres). *Contra*: ONTARIO 1 at 153 and rec. 4.

bank.[216] The Barreau du Québec would prohibit the creation of embryo banks devoted exclusively to storage for the purpose of donation or experimentation.[217] Most recommendations state that only authorized gamete banks or institutions may engage in such activities.[218]

B. Regulation of Technologies

A number of recommendations have been made concerning regulation of the technologies used in medically assisted procreation.

In New South Wales, it is recommended that the Biomedical Council, a statutory multidisciplinary agency comprising equal numbers of women and men, draw up a code of ethics that would outline the conditions for obtaining licences and set clinical standards and standards for research and the recording of information. The Council's role would be to advise the Minister for Health, inform the public, review the maximum storage period for gametes and embryos, settle disputes over access to information, and approve research projects. The overall authorization system would, however, be administered by the Department of Health.[219] There are no special regulatory provisions in the New South Wales legislation on artificial insemination.[220]

A statute passed by South Australia established the South Australian Council on Reproductive Technology, a multidisciplinary agency comprising equal numbers of women and men. The Council's role is to draft a code of ethics including clinical and research standards; advise the Department of Health on matters relating to medically assisted procreation and the conditions for issuing licences to practise; determine the conditions

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216. British Columbia 1, recs 19 and 21.

217. Quebec 1, rec. 26 at 39.

218. Denmark 1, rec. 6.1 at 124 and reg. 3.1 at 132; Spain 1, s. 20 (trade, import or export of embryos are prohibited); Council of Europe 1 at 20-21 and guideline 2; Delaware 1, s. 2801; France 1, s. 2, France 5, s. 10 — France 2, L. 668-2 and L. 676-4; Norway 1, ss 3 and 14; United Kingdom 2, ss 3, 4 and 41, and appendix 2, s. 2, United Kingdom 5, paras 13.7 and 13.13, recs 3, 17 and 50 at 80, 81 and 85, and United Kingdom 6, paras 27, 48, 49, 62 and 63; Sweden 1, s. 6; British Columbia 1, recs 19 to 21 (the creation of an institutional bank should be preferred over commercial and private banks except those under federal government supervision); Canada 2, rec. 8 (the CBA recommends the creation of provincial gamete banks), and Canada 3 at 14 and rec. 2.5 (import of sperm by commercial banks and creation of private banks outside the jurisdiction of a public agency are prohibited pending the adoption of regulations setting out federal quality standards); Ontario 1, recs 17 and 18 (the OLRC would allow banks to operate on a commercial basis as long as they are subject to government control); Quebec 1 at 25 and rec. 7 at 38.

219. New South Wales 4, recs 1, 2, 4 and 6. Half the members of the Council would be women because the impact of IVF is greater for women. See also New South Wales 3, paras 4.6 and 4.7, recs 1 and 2.

220. New South Wales 1.

for issuing research permits; conduct certain kinds of research; and inform the public and report to the Department and to Parliament. Permits and licences are issued by the Minister for Health.[221]

The legislation passed in the state of Victoria calls for a system of certification of clinics and consultants by the Minister for Health. Research and research permits are controlled by the Standing Review and Advisory Committee, a multidisciplinary agency that advises the government on all matters related to medically assisted procreation and prepares annual reports for Parliament.[222]

The Danish Council of Ethics proposes the establishment of a regulatory agency to handle the approval of research projects and certification of clinics that wish to offer medically assisted procreation services.[223]

In Spain, a statute dealing with all aspects of medically assisted procreation provides for the establishment of a National Commission on Assisted Reproduction. The multidisciplinary agency would advise and work with the government to compile data and establish operating criteria applicable to clinics and services. It may also be called upon to authorize research projects.[224]

In the United Kingdom, the first reports recommended the establishment of an agency separate from the government that would have regulatory power and would be responsible for monitoring and regulating infertility services, the storage of gametes and embryos, research, licences, and a central register of information.[225] As an interim measure, the Voluntary Licensing Authority — now called the Interim Licensing Authority — a body created jointly by the Medical Research Council and the Royal College of Obstetricians and Gynaecologists, carries out the role of this agency by urging centres to seek certification and apply for licences.[226] The new statute adopted in November 1990, the *Human Fertilisation and Embryology Act 1990*, incorporates these recommendations by creating a regulatory agency called the Human Fertilisation and Embryology Authority, which in turn will set up one or more committees to issue and revoke licences and permits. In addition to being in charge of the register of information, the agency will advise licensees and establish a code of practice dealing with the welfare of the child and the conduct of activities related to medically assisted procreation.[227]

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221. SOUTH AUSTRALIA 2, ss 5, 10 to 12; see also ss 13 to 16, regarding the conditions for issuing permits and the powers of the Department.

222. VICTORIA 1, ss 7 to 9A and 29.

223. DENMARK 1, recs 12.1 to 16.1 at 127-28. Regional agencies could also be established, see DENMARK 1 at 139-47.

224. SPAIN 1, ss 14 to 16 and 21. Section 5 calls for the establishment of a central data registry.

225. UNITED KINGDOM 5, paras 13.3 to 13.13, recs 1 to 3, 16, 17 and 50 at 80, 81 and 85, and UNITED KINGDOM 6, paras 13 to 27, 79 and 85.

226. UNITED KINGDOM 6, para. 9. See also UNITED KINGDOM 4 at 45 and 49.

227. UNITED KINGDOM 2, ss 5, 8, 9, 23, 25 and 31.

In Quebec, the report of the Department of Health and Social Services calls for the development of minimum clinical and ethical standards that would be incorporated in the Department's system of certifying and evaluating clinics. A provincial network of clinics would be set up, and clinics would be responsible for compiling and publishing uniform data on the services provided. Monitoring the evolution of practices would be left to the academic community and to interested agencies.[228] Also, the Status of Women Council suggests that the Department of Health and Social Services set up a multidisciplinary ad hoc committee to supervise the development of certification standards that specialized centres would have to meet, as well as mechanisms for evaluating, monitoring and checking the quality of practices.[229] The government should also set up an ethics advisory body comprising representatives of society at large rather than experts, to advise and express ethical opinions on medically assisted procreation.[230] Finally, enabling legislation should be passed.[231]

In short, the agencies recommended to regulate medically assisted procreation have similar responsibilities and structures.

Although the initiatives taken around the world to identify the issues raised by the technologies used in medically assisted procreation vary in scope, our study of the legislative provisions and recommendations seems to indicate that the advent of these technologies is accepted with at least some reservations and that there is consensus on a number of basic principles.

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228. QUEBEC 5, recs 65 to 76.

229. QUEBEC 4 at 25, recs 6.1, 6.5 and 6.6. The number of certified specialized centres would be limited to five, the number of centres now in existence. At the end of the committee's brief mandate, the recommendations on practical conditions would give way to standards issued by the Department for the recognition of clinics. Periodic monitoring and evaluation would be needed.

230. QUEBEC 4 at 25-26, rec. 6.5. The mandate would include qualitative management of births, evaluation and monitoring of practice and research, and distribution of information to the public. The agency would be given access to the annual reports of certified centres so that it could conduct general evaluations of the services provided. Women should be strongly represented.

231. QUEBEC 4 at 26, rec. 6.6.

TABLE 1: Eligibility for Medically Assisted Procreation Services (Except Surrogacy)

Text*	Unmarried Heterosexual Couple	Single Woman	Women in Homosexual Relationship
NEW SOUTH WALES 1	Authorized	Not excluded, restrictive criteria to be considered	—
NEW SOUTH WALES 3 (AI) NEW SOUTH WALES 4 (IVF)			
SOUTH AUSTRALIA 2	Authorized (cohabitation for at least 5 years)	Excluded	Excluded
VICTORIA 1	Authorized	Excluded for IVF	Excluded for IVF
BRITISH COLUMBIA 1	Authorized	Not excluded	Not excluded
CANADA 2	Authorized	Not excluded	—
CANADA 4	Authorized	Authorized	Authorized
CANADA 5	Authorized	Authorized	Authorized
ONTARIO 1	Authorized	Authorized	—
QUEBEC 1	Authorized	Excluded	Excluded
QUEBEC 4	Authorized	Excluded	Excluded
QUEBEC 5	Authorized	Authorized for AI	Authorized for AI
COUNCIL OF EUROPE 1	Authorized	Excluded	Excluded
DENMARK 1	Authorized	Authorized	Authorized
FRANCE 5	Authorized	Excluded	Excluded
NORWAY 1	Excluded	Excluded	Excluded

*See List of Texts Cited, *infra* at 214-20.

TABLE 1: Eligibility for Medically Assisted Procreation Services (Except Surrogacy) (*Concluded*)

Text*	Unmarried Heterosexual Couple	Single Woman	Women in Homosexual Relationship
SPAIN 1	Authorized	Authorized	—
SWEDEN 1 (AI) SWEDEN 3	Authorized	Excluded	Excluded
SWEDEN 2 (IVF)	Authorized	Excluded	Excluded
UNITED KINGDOM 2	Authorized	Not excluded	—
UNITED KINGDOM 5	Authorized	Not excluded, but preference to heterosexual couples	Not excluded, but preference to heterosexual couples
UNITED STATES 1	Authorized	Authorized	—
UNITED STATES 2	Authorized	Authorized (in special circumstances)	—

*See List of Texts Cited, *infra* at 214-20.

TABLE 2: Conditions for Access to Medically Assisted Procreation Services (Except Surrogacy)

Text*	Infertility or Genetic Disorder	Welfare of Child	Stability	Consent of Partner	Other Criteria	Decision
NEW SOUTH WALES 1 NEW SOUTH WALES 3 (AI) NEW SOUTH WALES 4 (IVF)	Considered for couples	Considered	Considered	—	Need for counselling, physical and psychological health of future parents	By physician — professional sanction if physician fails to consider criteria, even if they are not mandatory
SOUTH AUSTRALIA 2	Required	—	—	—	—	—
VICTORIA 1	1 year of alternative treatment required, except for AI	Required	—	Required, except for AI	Counselling mandatory	By physician
BRITISH COLUMBIA 1	—	—	—	Required for married couples	Parental qualities as for adoption required	By physician according to criteria — appeal possible
CANADA 2	—	—	—	—	—	By physician
CANADA 4	—	—	Required	—	—	—
ONTARIO 1	Required for couples	—	Required	—	—	By physician according to criteria — appeal possible
QUEBEC 1	Infertility required	—	Required for unmarried couples	—	—	—

*See List of Texts Cited, *infra* at 214-20.

TABLE 2: Conditions for Access to Medically Assisted Procreation Services (Except Surrogacy) (*Continued*)

Text*	Infertility or Genetic Disorder	Welfare of Child	Stability	Consent of Partner	Other Criteria	Decision
QUEBEC 4	Required	—	—	—	—	—
QUEBEC 5	Required	—	—	—	—	—
COUNCIL OF EUROPE 1	Required	Required	—	—	Reasonable chance of success — low risk to mother's or child's health	By physician
DENMARK 1	—	—	—	Required	—	—
FRANCE 5	Required	—	—	Required	Procedure applied by physician or under physician's supervision	Criminal sanction for anyone who violates the criteria established by the preliminary draft legislation
NORWAY 1	Required	—	—	Required	Medical and psychosocial assessment of couple	By physician

*See List of Texts Cited, *infra* at 214-20.

TABLE 2: Conditions for Access to Medically Assisted Procreation Services (Except Surrogacy) (*Concluded*)

Text*	Infertility or Genetic Disorder	Welfare of Child	Stability	Consent of Partner	Other Criteria	Decision
SPAIN 1	—	—	—	Required for married couples	Reasonable chance of success; good physical and psychological health; woman must be at least 18 years old	—
SWEDEN 1 (AI) SWEDEN 3	—	Required	—	Required	Medical, psychological and social assessment of couple	By physician — appeal possible
SWEDEN 2 (IVF)	—	—	—	Required	—	—
UNITED KINGDOM 2	—	Required	—	—	—	—
UNITED KINGDOM 5	—	—	—	Recommended	—	By physician, who must justify refusal
UNITED STATES 1	—	—	—	Required	—	—

*See List of Texts Cited, *infra* at 214-20.

TABLE 3: Time Limits Applicable to the Storage and Commercial Use of Gametes and Embryos

Text*	Time Limits		Authorized Payments		Trade**	
	Gametes	Embryos	Gametes	Embryos	Gametes	Embryos
NEW SOUTH WALES 1 (AI)	—	—	Fixed amount or reimbursement of expenses (sperm)	—	Prohibited	—
NEW SOUTH WALES 3 (AI)	—	—	Fixed amount and reimbursement of necessary or reasonable expenses (sperm)	—	—	—
NEW SOUTH WALES 4 (IVF)	—	10 years	—	—	—	—
SOUTH AUSTRALIA 2	—	10 years, with annual review (donor)	—	—	—	—
VICTORIA 1	—	—	Travel costs, medical expenses, and other costs	—	Prohibited	Prohibited
BRITISH COLUMBIA 1 (AI)	—	—	Expenses, time, lost wages (sperm)	—	—	—
CANADA 1	—	—	—	—	Forbidden	Forbidden
CANADA 2	—	5 years	—	—	—	—
CANADA 3	—	—	Inconvenience, time, travel costs (sperm)	—	—	—

*See List of Texts Cited, *infra* at 214-20.

**For the purposes of this table, the term "prohibited" implies the intervention of the criminal law, while the term "forbidden" implies any other type of unspecified sanction.

TABLE 3: Time Limits Applicable to the Storage and Commercial Use of Gametes and Embryos (*Continued*)

Text*	Time Limits		Authorized Payments		Trade**	
	Gametes	Embryos	Gametes	Embryos	Gametes	Embryos
CANADA 4 (AI)	—	—	Expenses and inconvenience (sperm)	—	—	—
CANADA 5	—	—	Expenses and inconvenience	—	If public funding is inadequate, possibility of establishment of profit-oriented banks	—
ONTARIO 1	—	10 years	Reasonable expenses, time and inconvenience; excludes discomfort; may be higher for ovum	—	Commercial banks permitted (according to regulations)	Commercial banks permitted (according to regulations)
QUEBEC 1	To be determined	To be determined	Actual expenses	—	Forbidden	Forbidden
QUEBEC 4	—	—	No payment (sperm)	—	—	—
QUEBEC 5	—	2 years (may be extended in special circumstances)	Reasonable costs, to be borne by recipient (sperm)	—	Forbidden	Forbidden
QUEBEC 6	—	—	—	—	—	Forbidden

*See List of Texts Cited, *infra* at 214-20.

**For the purposes of this table, the term "prohibited" implies the intervention of the criminal law, while the term "forbidden" implies any other type of unspecified sanction.

TABLE 3: Time Limits Applicable to the Storage and Commercial Use of Gametes and Embryos (*Continued*)

Text*	Time Limits		Authorized Payments		Trade**	
	Gametes	Embryos	Gametes	Embryos	Gametes	Embryos
COUNCIL OF EUROPE 1	To be determined	To be determined	Expenses, travel costs, lost wages	Expenses, travel costs, lost wages	Forbidden	Forbidden
DENMARK 1	—	1 year	—	—	—	Forbidden
FRANCE 5	To be determined	5 years	Expenses, excludes lost wages	—	Profit forbidden	—
NORWAY 1	—	1 year	—	—	—	—
SPAIN 1	5 years	5 years	—	—	—	Forbidden
SWEDEN 1 (AI) SWEDEN 2 (IVF)	—	—	—	—	Profit forbidden	—
UNITED KINGDOM 2	10 years	5 years	—	—	Forbidden	Forbidden
UNITED KINGDOM 4	—	10 years, with review every 2 years	—	—	Forbidden (ovum)	—
UNITED KINGDOM 5	Review every 5 years	10 years, with review every 5 years	Expenses (sperm)	—	Authorized with the approval of the regulatory agency	Authorized with the approval of the regulatory agency
UNITED KINGDOM 6	10 years	5 years	Reasonable costs	Reasonable costs	Authorized with the approval of the regulatory agency	Authorized with the approval of the regulatory agency

*See List of Texts Cited, *infra* at 214-20.

**For the purposes of this table, the term "prohibited" implies the intervention of the criminal law, while the term "forbidden" implies any other type of unspecified sanction.

TABLE 3: Time Limits Applicable to the Storage and Commercial Use of Gametes and Embryos (*Concluded*)

Text*	Time Limits		Authorized Payments		Trade**	
	Gametes	Embryos	Gametes	Embryos	Gametes	Embryos
UNITED STATES 1	—	—	Expenses and time (sperm)	—	—	—
UNITED STATES 2	—	—	Expenses and time (sperm) Expenses, time, risks and inconvenience (ovum)	Expenses and inconvenience	—	—

*See List of Texts Cited, *infra* at 214-20.
**For the purposes of this table, the term "prohibited" implies the intervention of the criminal law, while the term "forbidden" implies any other type of unspecified sanction.

TABLE 4: Surrogacy*

Text**	General Position	Involvement of Intermediaries	Advertising	Payment	Contract
AUSTRALIA 1	Commercialization prohibited	Prohibited	Prohibited	Prohibited	Null
COMMONWEALTH OF AUSTRALIA 3	Permitted under strict control	Controlled	Controlled	—	Null
NEW SOUTH WALES 5	Surrogacy discouraged Commercialization prohibited	Prohibited (including professional and attorney)	Prohibited	Prohibited	Null
QUEENSLAND 2	Surrogate motherhood prohibited	Prohibited	Prohibited	Prohibited	Null
SOUTH AUSTRALIA 1	Commercialization prohibited	Prohibited if payment	Prohibited	Prohibited for intermediaries	Null
VICTORIA 1	Commercialization prohibited	Prohibited if payment	Prohibited	Prohibited	Null
CANADA 2	Opposed to the prohibition of surrogacy Commercialization prohibited	—	—	Prohibited	Legal, but null vis-à-vis surrogate mother
CANADA 5	Permitted for medical reasons on experimental basis	—	—	Permitted for surrogate mother for direct and indirect costs	—
ONTARIO 1	Regulation of contracts	Regulated	—	Permitted for surrogate mother if approved by court	Enforceable if approved by court

*For the purposes of this table, the term "prohibited" implies the intervention of the criminal law, while the term "forbidden" implies any other type of unspecified sanction.
**See List of Texts Cited, *infra* at 214-20.

TABLE 4: Surrogacy* (*Continued*)

Text**	General Position	Involvement of Intermediaries	Advertising	Payment	Contract
QUEBEC 1	Surrogacy strictly forbidden	Prohibited	—	—	Null
QUEBEC 4	Prevent surrogacy agreements Commercialization prohibited	Prohibited	Forbidden	—	—
QUEBEC 5	Generally opposed to surrogacy Commercialization prohibited	Prohibited	Forbidden vis-à-vis intermediaries	—	—
QUEBEC 6	Surrogacy forbidden	Forbidden	Forbidden	—	—
COUNCIL OF EUROPE 1	Commercialization forbidden Member states may permit altruistic agreements	Forbidden (except medical services by physician in exceptional cases)	Forbidden	Forbidden	Null
FRANCE 5 FRANCE 4	Surrogacy prohibited	Prohibited	—	—	Null
GERMANY 1	Surrogacy prohibited	Prohibited	—	—	—
SPAIN 1	Surrogacy discouraged	—	—	—	—
UNITED KINGDOM 1	Commercialization prohibited	Prohibited if payment	Prohibited	Prohibited vis-à-vis intermediaries	Null

*For the purposes of this table, the term "prohibited" implies the intervention of the criminal law, while the term "forbidden" implies any other type of unspecified sanction.
**See List of Texts Cited, *infra* at 214-20.

TABLE 4: Surrogacy* (*Continued*)

Text**	General Position	Involvement of Intermediaries	Advertising	Payment	Contract
UNITED KINGDOM 5	Commercialization prohibited	Prohibited for both profit and non-profit agencies (including professionals)	—	—	Null
UNITED KINGDOM 6	Surrogacy discouraged Commercialization prohibited	Prohibited vis-à-vis commercial agencies	—	—	Null
MICHIGAN 1	Commercialization prohibited	Prohibited if payment	—	Prohibited except reasonable expenses incurred by surrogate mother	Null
NEW YORK 2	Commercialization prohibited	Prohibited if payment (excludes physician's costs for AI and IVF)	—	Prohibited except reasonable expenses incurred by surrogate mother (affidavit setting out all payments received must be submitted to court), excluding loss of wages	Null

*For the purposes of this table, the term "prohibited" implies the intervention of the criminal law, while the term "forbidden" implies any other type of unspecified sanction.
**See List of Texts Cited, *infra* at 214-20.

TABLE 4: Surrogacy* (*Concluded*)

Text**	General Position	Involvement of Intermediaries	Advertising	Payment	Contract
UNITED STATES 2	Opposed to legal prohibition Authorized for medical reason as clinical experimentation	Permitted if costs limited or professional services	—	Compensation for surrogate expenses and inconveniences, at least, is authorized; costs to intermediaries	—

*For the purposes of this table, the term "prohibited" implies the intervention of the criminal law, while the term "forbidden" implies any other type of unspecified sanction.
**See List of Texts Cited, *infra* at 214-20.

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APPENDIX B

Proposed Contents of a Medically Assisted Procreation Act

Note

The following text is not intended to represent draft legislation on medically assisted procreation. It was put together in order to provide a comprehensive legislative approach to the control of most aspects of medically assisted procreation. In order to achieve such a goal we did not take into consideration the division of powers between the various levels of government. It is obvious that, within our constitutional framework, co-operative agreements between the federal, provincial and territorial governments would be necessary to put such control mechanisms in place. However, the details of such agreements would take us beyond the scope of this working paper. In order to provide as complete a text as possible, we had to be more affirmative than some of our recommendations, and we took the position that agreements between the different levels of government would be worked out.

Along with such agreements and legislation, provincial legislation would be necessary to deal with such issues as parentage and succession.

PROPOSED CONTENTS OF A MEDICALLY ASSISTED PROCREATION ACT

SHORT TITLE

1.

INTERPRETATION

2. In this Act,

"central registry"

"certification"

"certified clinic"

"counselling services"

"deposit"

"donation"

"embryos"

"gamete"

"genetic predisposition"

"genetic trait"

"import"

"inspector"

"medically assisted procreation"

"national agency"

etc.

DECLARATION OF PRINCIPLES

3. It is hereby recognized and declared that

(*a*) medically assisted procreation technologies should be developed and used in accordance with the fundamental principles of equality and justice and in a manner that respects the sanctity of life and the dignity and inviolability of the person;

(*b*) the use of medically assisted procreation technologies to select or avoid the transmission of genetic predispositions or traits is unacceptable except where specifically provided for;

(*c*) commercialization of medically assisted procreation is unacceptable;

(*d*) access to medically assisted procreation should not be limited on the basis of any criterion that relates to the family status, marital status or sexual orientation of the candidate;

(*e*) a person should have the opportunity through counselling services to be fully informed prior to making a decision to use a medically assisted procreation technology; and

(*f*) the establishment of standards for public safety in relation to the use of medically assisted procreation technologies is essential.

ACCESS TO MEDICALLY ASSISTED PROCREATION SERVICES

4. Limitation on Access

No one should be denied access to medically assisted procreation services, unless cost or scarcity of resources requires that candidates undergo a selection process. If a selection process is required, the family status, marital status or sexual orientation of the candidate should not be used as selection criteria.

GAMETES AND EMBRYOS

5. Possible Uses of Gametes and Embryos

(1) Gametes. The possible uses of gametes should be limited to fertilization, experimentation and destruction; however, fertilization should be prohibited beyond the time limit on freezing prescribed by regulation [recommendations 6(4) and 12(2)] and donated sperm should not be used for fertilization until the donor has been properly tested for evidence of the AIDS virus [recommendation 11].

(2) Embryos. The possible uses of embryos should be limited to implantation, experimentation and destruction; however, implantation should be prohibited beyond the time limit on freezing [recommendations 5(3) and 12(1)].

(3) Offence.

6. Selection of Gametes and Embryos

(1) Limits. To eliminate the possibility of eugenic practices, the selection of gametes and embryos with specific qualities should be prohibited [recommendation 2].

(2) Exception. However, such selection should be permitted when the objective is to prevent the transmission of serious genetic diseases [recommendation 2].

(3) Offence.

7. Commercialization

(1) Gamete and Embryo Donation. All commercialization of the donation of gametes and embryos should be prohibited [recommendation 3(1)].

(2) Exception. Only reimbursement of reasonable expenses incurred by donors should be permitted [recommendation 3(1)].

(3) Gamete and Embryo Banks. Gamete and embryo banks should not be permitted to operate on a profit basis [recommendation 3(2)].

(4) Exception. Banks should be allowed to be reimbursed for reasonable costs related to their operations [recommendation 3(2)].

(5) Offence.

8. Control over Gametes and Embryos in Case of Deposit and Donation

(1) Control over Gametes. Control over gametes should be vested in the person from whom the gametes are derived [recommendation 6(1)].

(2) Control over Embryos.

(*a*) Control over embryos should be vested in both partners, if each partner contributed gametes used to conceive the embryos;

(*b*) control over embryos should be vested in the partner genetically linked to the embryos, if only one partner contributed gametes used to conceive the embryos; and

(*c*) control over embryos should be vested in the bank or clinic in possession of the embryos, if the gametes used to create the embryos were both donated. [recommendation 5(2)].

(3) Deposit of Gametes.

(*a*) The person with control who wishes to deposit his or her gametes for future personal use should be required, before the deposit, to make a written statement expressing his or her intentions as to the fate of the gametes;

(*b*) the statement must include provisions for the fate of the gametes in such circumstances as death of the person with control, abandonment of the parental project or expiry of the time limit on freezing; and

(*c*) the depositor should be able to change his or her stated intentions regarding the fate of the gametes by making a written statement to that effect before the gametes are used to create an embryo or used for any other intended purpose. [Recommendation 6(2)].

(4) Deposit of Embryos.

(*a*) Before conceiving an embryo for future personal use, the person with control should be required to make a written statement expressing his or her intentions as to the fate of the embryos. If control over the embryos is vested in both partners, their joint intentions are to be expressed in one written statement.

(*b*) The statement must include provisions for the fate of the embryo in such circumstances as death of the person or persons with control, abandonment of the parental project, expiry of the time limit on freezing, or divorce or other dispute between the persons with control.

(*c*) The person with control should be able to change his or her stated intentions regarding the fate of the embryo by making a written statement to that effect before the embryo is used for its intended purpose. If control over the embryo is vested in both partners, both must agree to any changes. [Recommendations 5(1) and (2)].

(5) Donation of Gametes.

(*a*) The person with control who wishes to donate his or her gametes should be required, before the donation is made, to make a written statement consenting to the donation and stating the conditions attached to his or her donation respecting the use of the gametes; and

(*b*) the donor should be able to withdraw his or her consent to the donation or change the conditions by making a written statement to that effect before the gametes are used to create an embryo or are used for another intended purpose. [Recommendation 6(3)].

(6) Donation of Embryo.

(*a*) The person with control who wishes to donate an embryo should be required, before the donation is made, to make a written statement consenting to the donation and should be able to attach to the statement conditions as to the use of the embryo. If control over the embryo is vested in both partners, their joint consent and conditions are to be expressed in one written statement.

(*b*) The donor should be able to withdraw his or her consent to the donation or change the conditions by making a written statement to that effect before the embryo is used for its intended purpose. If control over the embryo is vested in both partners, both must agree to the withdrawal of consent or any other changes. [Recommendation 5(4)].

(7) Offence.

9. Import of Gametes and Embryos

(1) Restriction. Importation of gametes and embryos should be restricted to certified banks. Imported gametes and embryos should also meet established national standards [recommendation 14].

(2) Offence.

CLINICS AND BANKS

10. Restriction of Services

(1) Clinics. The application of medically assisted procreation technologies should be restricted to certified clinics [recommendation 21(2)].

(2) Banks. Only certified banks should be permitted to store gametes and embryos [recommendation 21(2)].

(3) Offence.

11. Counselling Services

Every clinic offering medically assisted procreation services should be required to provide counselling services whereby persons using these services may obtain information and assistance from psychologists, physicians or other experts, either before, during or after the technology is applied [recommendation 16].

12. Maintenance and Use of Records

(1) Obligation to Keep Records. Clinics should be required to keep records (on the donor, the mother and the child) that allow physicians to link the donor to the recipient while protecting the anonymity of the parties [recommendation 17(1)].

(2) Limit on the Information to Be Kept. Only the information needed to attain the following objectives should be collected: to permit access to medical and genetic information that may be needed to obtain optimum medical care for the child; to meet the psychological needs of the child; to ensure proper clinical reports and to permit studies on the long-term effects of the various technologies used in medically assisted procreation [recommendation 17(2)].

(3) Protection of Confidentiality. Clinics should be responsible for protecting the confidentiality of the information they hold [recommendation 17(3)].

(4) Access to Information/Anonymity. The legal parents or the child should be able to request disclosure of non-identifying information such as social information (about the ethnic origin, profession, education, religious affiliation and interests of the donor, for example). However, identifying information should be disclosed only with the donor's consent [recommendation 18].

(5) Exception. It should be possible to reveal to the prosecuting authorities the identity of any donor who fails to provide information or who provides false information about his or her medical or genetic history, for the purpose of a criminal prosecution related to such failure or false information [recommendation 19].

(6) Offence.

13. Annual Reports from Clinics

(1) Obligation to File Annual Reports. Clinics offering medically assisted procreation services should be required to submit written annual reports to a central registry [recommendation 9].

(2) Content of Reports. The minimum content of the reports should be set by regulation and the data should be presented in the prescribed form [recommendation 9]. The clinics should also be required to document and justify the number of embryos implanted in each treatment cycle [recommendation 15].

(3) Offence.

NATIONAL AGENCY

14. Establishment of a National Agency

The federal, provincial and territorial governments, in conjunction with the professionals involved, should establish a national regulatory agency on medically assisted procreation [recommendation 22(1)].

15. Powers and Duties of Agency

(1) Establishment of Certification System. The national agency should establish a system of certification for clinics offering medically assisted procreation services and gamete and embryo banks [recommendation 21(1)].

(2) Regulations. The national agency should be empowered to make regulations [recommendation 22(2)(b)]

(*a*) prescribing the criteria for granting certification to a bank or clinic;

(*b*) establishing standards for the selection and screening of gamete and embryo donors [recommendation 10], and prescribing the maximum number of gametes that may be used from one donor [recommendation 13];

(*c*) establishing standards for the screening, storage [recommendation 10] and importation of gametes and embryos [s. 9];

(*d*) prescribing time limits respecting the freezing of gametes and embryos [[s. 5];

(*e*) respecting the prohibitions pertaining to the selection of gametes and embryos [s. 6] and to the commercialization of gamete and embryo donation [s. 7];

(*f*) respecting the reimbursement of costs incurred by donors and costs incurred by banks [s. 7];

(*g*) respecting the exercise of control over gametes and embryos, including the attachment of conditions to donation and the expression of intentions in the case of deposit [s. 8];

(*h*) respecting the composition and duties of counselling services established by clinics [s. 11];

(*i*) respecting the maintenance of records by clinics and the contents of the records [s. 12(1) and (2)];

(*j*) respecting the procedure for the release by clinics of identifying and non-identifying information about donors [s. 12(3) and (4)]; and

(*k*) respecting the content of annual reports submitted by clinics to the central registry [s. 13(1) and (2)].

(3) Additional Powers and Duties. The national agency should be given the following powers and duties:

(*a*) to take steps necessary to ensure compliance with the Act and regulations;

(*b*) to grant certification to a clinic or bank;

(*c*) to inspect certified clinics and banks [recommendation 22(2)];

(*d*) to amend, suspend or revoke the certification of a clinic or bank that fails to comply with the Act or regulations or with the terms of its certification [recommendation 22(2)];

(*e*) to establish a central registry which would collect annual reports from clinics and make available to the public the statistics derived from it;

(*f*) to analyse medically assisted procreation success rates and other information collected from the annual reports of clinics and compile statistics;

(*g*) to take steps necessary to prevent exploitation and commercialization in the area of medically assisted procreation;

(*h*) to promote research and studies in relation to medically assisted procreation technology, including research and studies aimed at reducing the number of multiple pregnancies, at developing technologies that follow the normal cycle of ovulation [recommendation 15] and at determining the long-term effects (medical and psychological) of medically assisted procreation technology on children born as a result of the technology [recommendation 20];

(*i*) to identify problems arising from medically assisted procreation on the basis of national data; and

(*j*) to advise governments on matters related to medically assisted procreation.

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du droit du Canada

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* Lorsque ce document de travail a été approuvé, M. le juge Linden venait de quitter la Commission, mais il a participé à toutes les étapes de son élaboration ; Mme la juge Rivet était commissaire et Me Trevor-Deutsch était coordonnateur de la Section de recherche. Mme la juge Picard et M. le professeur Frémont se sont joints à la Commission après l'approbation du document.

Note de la rédaction

Conformément à la recommandation formulée dans le document intitulé *Égalité pour tous — Rapport du Comité parlementaire sur les droits à l'égalité*, nous nous sommes fait un devoir de rédiger le présent document de travail dans une langue non sexiste. Dans cette optique, et puisque le mandat de la Commission consiste à formuler des propositions en vue de moderniser les lois fédérales canadiennes, nous nous sommes conformés aux principes énoncés dans l'ouvrage publié sous le titre *Cap sur l'égalité — Réponse au Rapport du Comité parlementaire sur les droits à l'égalité*, relativement à la rédaction des textes législatifs. Le genre grammatical des noms et pronoms utilisés pour désigner des personnes (« médecin », « patient », etc.) ne doit donc en aucun cas être interprété comme une indication du sexe de ces personnes.

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Introduction

Les progrès technologiques et l'avancement de la science — particulièrement de la science médicale — posent sans cesse de nouveaux défis à nos institutions politiques et juridiques. Le législateur, sous les pressions sociales, morales, politiques et économiques, doit réviser systématiquement les règles de droit et les pratiques qui en découlent. Le droit, pour sa part, doit tenir compte de l'évolution scientifique et la promouvoir, mais aussi la contenir dans les limites dictées par certaines valeurs humaines et sociales. La procréation médicalement assistée constitue probablement l'un des plus beaux exemples du défi que pose le développement de la science médicale, et des tensions qui en résultent pour le droit.

De fait, l'intérêt national et mondial que suscite cette question est le reflet de l'importance que l'on attache aux risques et aux conséquences sociales et juridiques des techniques utilisées. Que ce soit dans le but d'élaborer des politiques en la matière ou d'éliminer les ambiguïtés juridiques[1], la société doit s'interroger sur les choix à faire face aux conflits existants et à la remise en question de certaines valeurs fondamentales et de certains principes de droit. La définition de la famille, la filiation des enfants nés grâce à la procréatique, la mercantilisation de la procréation, du corps humain et de ses produits et substances, de même que le statut juridique des gamètes et des embryons, sont autant de thèmes qui soulèvent de sérieuses interrogations. Les risques physiques et psychologiques, plus ou moins immédiats, que comportent les techniques en cause, soulèvent pour leur part des inquiétudes quant à la protection du public et, notamment, celle des enfants qui doivent leur existence à ces techniques. Il y a donc lieu de s'interroger aussi sur la suffisance des mécanismes régissant la procréation médicalement assistée et la sélection et la conservation des gamètes et des embryons.

L'élaboration d'une politique sociale canadienne uniforme en matière de procréation médicalement assistée n'est cependant pas sans poser de difficultés. Ainsi, les positions diamétralement opposées qu'expriment les rapports de la Commission de réforme du droit de l'Ontario[2] et du Barreau du Québec[3] sur certains aspects fondamentaux de la question sont révélatrices de ces difficultés. D'autre part, le partage des pouvoirs prévu par la Constitution canadienne entre les provinces et le Parlement fédéral ne facilite en rien la tâche.

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1. L'incertitude juridique peut être à l'origine d'importants drames personnels, familiaux et sociaux. Les affaires américaines *Baby M*, *infra*, note 305, *Davis* c. *Davis*, *infra*, note 207, *York* c. *Jones Institute*, *infra*, note 208, ainsi que l'affaire des embryons orphelins, *Rios*, *infra*, note 208, illustrent bien cette possibilité.

2. Commission de réforme du droit de l'Ontario, *Report on Human Artificial Reproduction and Related Matters*, vol. 1 et 2, Toronto, Ministère du Procureur général, 1985 (ci-après CRDO).

3. Barreau du Québec, « Rapport du Comité sur les nouvelles technologies de reproduction » (1988), 48:2 (suppl.) *R. du B.*

La complexité et l'importance des enjeux nécessitent donc une réflexion profonde et des discussions sérieuses de la part de la société canadienne. C'est d'ailleurs dans cette optique que s'inscrit la décision du gouvernement canadien de former la Commission royale sur les nouvelles techniques de reproduction[4]. Structure ponctuelle, la Commission royale n'a pas pour mission de remplacer quelque organisme permanent que ce soit. Elle a le mandat de faire enquête et de présenter un rapport sur les sujets suivants : les progrès actuels et prévisibles de la science et de la médecine en matière de procréation assistée, les répercussions des techniques en cause sur la santé et la recherche, de même que les conséquences morales, sociales, économiques et juridiques de leur utilisation. Enfin, la Commission royale doit recommander des politiques et des mesures de protection à l'égard d'une série de questions liées à ce domaine[5]. Elle doit présenter son rapport en octobre 1992[6].

C'est dans le but de participer à l'avancement de cette réflexion sociale et de poursuivre sa trilogie d'études dans le domaine du droit médical et de la procréation que la Commission de réforme du droit du Canada a entrepris l'étude de la procréation médicalement assistée[7]. En mai 1988, le groupe de travail créé par la Commission pour examiner le statut juridique du fœtus recommandait que la procréatique fasse l'objet d'études de la part de la Commission. Dans son document de travail *Les crimes contre le fœtus*, celle-ci

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4. C.P. 1989-2150, C.P. 1991-524. La Commission royale a été formée en vertu de la Partie I de la *Loi sur les enquêtes*, L.R.C. (1985), ch. I-11. Cette loi prévoit entre autres que les commissaires peuvent contraindre des témoins à comparaître devant eux (art. 4).

5. C.P. 1989-2150. La Commission est chargée de faire enquête et de faire rapport « au sujet principalement ;

   a) des répercussions des nouvelles techniques de reproduction sur le bien-être et la fertilité des femmes ;

   b) des causes, du traitement et de la prévention de l'infertilité chez les hommes et les femmes ;

   c) de la réversibilité des techniques de stérilisation, de l'insémination artificielle, de la fécondation *in vitro*, des transplantations d'embryons, des techniques de dépistage et de diagnostic prénatals, de la manipulation génétique et des interventions thérapeutiques pour corriger des anomalies génétiques, des techniques de choix du sexe, des expériences sur l'embryon et des transplantations de tissu foetal ;

   d) des mesures d'ordre social ou juridique, telles le recours à une mère porteuse, l'intervention de la justice durant la grossesse et à la naissance, et la "propriété" de l'ovule, du sperme, de l'embryon et du tissu foetal ;

   e) du statut et des droits des personnes qui recourent ou contribuent aux services de reproduction, entre autres, l'accès aux diverses méthodes, les "droits" à la condition de parent, le consentement en toute connaissance de cause, le statut des donneurs de gamètes et la confidentialité, ainsi que l'incidence de ces services sur tous les intéressés, notamment sur les enfants ; et

   f) des ramifications économiques de ces techniques, par exemple, l'utilisation commerciale d'ovules, de sperme et d'embryons, l'application de la Loi sur les brevets, et le financement de la recherche et des méthodes utilisées, y compris le traitement de l'infertilité. »

6. C.P. 1991-524.

7. La première étude portait sur la protection du foetus par le droit criminel : COMMISSION DE RÉFORME DU DROIT DU CANADA (ci-après CRD), *Les crimes contre le fœtus*, Document de travail n° 58, Ottawa, la Commission, 1989. La deuxième portait sur l'expérimentation sur l'être humain : *L'expérimentation biomédicale sur l'être humain*, Document de travail n° 61, Ottawa, la Commission, 1989.

soulignait la nécessité de s'interroger sur la maternité de substitution, d'élaborer des normes nationales vu le risque de « tourisme interprovincial », et de définir la responsabilité des donneurs qui fournissent de faux renseignements concernant leur état de santé (affections génétiques, maladies héréditaires, antécédents médicaux) ou qui omettent de donner des renseignements pertinents[8]. La Commission a donc entrepris une étude approfondie des différentes techniques de reproduction présentement utilisées, y compris la maternité de substitution.

Mentionnons également que les inquiétudes qui bouleversent notre société ne sont pas étrangères à la décision de la Commission d'entreprendre une telle étude. Car l'expression de ces craintes emporte souvent un appel à l'intervention de l'État, sous forme de limites ou de contrôles que l'on justifie au nom de l'ampleur des coûts, de la nécessité de baliser les progrès de la médecine, du risque de la mercantilisation de la procréation, de la protection de la cellule familiale et des valeurs morales et, enfin, de la protection de l'embryon, de l'enfant, des couples infertiles et surtout des femmes contre l'exploitation.

Cette demande émane généralement de personnes ou de groupes dont les intérêts s'opposent parfois à ceux des premiers intéressés (personnes infertiles ou stériles, médecins, scientifiques, etc.), ce qui peut engendrer une instabilité juridique et sociale. Devant cette instabilité et l'insuffisance des autres mécanismes sociaux[9], l'intervention législative peut s'avérer nécessaire afin de définir et de régir les rapports entre les parties et les groupes sociaux concernés, et de rétablir ainsi l'équilibre social. En cette matière, peut-être plus qu'en toute autre, il faut se garder d'une action précipitée. Il convient d'abord de s'interroger sur la nécessité d'une réforme puis, le cas échéant, sur l'ampleur qu'elle doit prendre.

D'autre part, ces demandes sociales font appel à différents aspects du droit qui revêtent, cela va sans dire, un intérêt particulier pour un organisme de réforme du droit : le droit comme instrument de changement des structures sociales, le droit comme protecteur des valeurs fondamentales de notre société, le droit comme agent régulateur.

Notre étude a été guidée par certains grands thèmes. Pour commencer, nous nous sommes interrogés sur l'opportunité d'une intervention étatique dans le but de limiter l'accès à la procréatique ou d'en réglementer l'application. Nous avons examiné les aspects médicaux de la procréatique qui font problème, ainsi que la suffisance des contrôles sociaux ou professionnels existants pour protéger le public (risques physiques et psychologiques,

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8. *Op. cit.*, note 7, p. 65. *Ibid.*, « La réglementation des pratiques médicales relève de la compétence provinciale. Or, vu l'absence de procédure d'accréditation uniforme à l'échelle nationale et l'inexistence de restrictions applicables aux établissements, il faut tenir compte du risque de "tourisme interprovincial" pour le recours aux nouvelles techniques de reproduction, et examiner la question sérieusement. »

9. Pour l'étude des mécanismes de réglementation actuels en matière de procréatique, voir *infra*, ch. III. Sur les lacunes du droit positif, voir *infra*, ch. II. Voir également, sur le rôle des forces sociales, Robert L. Kidder, *Connecting Law and Society: An Introduction to Research and Theory*, Englewood Cliffs (N.J.), Prentice-Hall, 1983.

normes de sélection, de dépistage et de conservation, taux de succès, tenue et contenu des dossiers, et accès à l'information médicale et génétique). Nous nous sommes également arrêtés à la nécessité de revoir et, au besoin, d'adapter le droit aux problèmes particuliers que posent le don et le dépôt de gamètes et d'embryon (propriété du matériel génétique et responsabilité des donneurs), et la filiation des enfants en cause. Enfin, nous nous sommes penchés sur les aspects juridiques de la maternité de substitution et sur le caractère commercial que tend à prendre la procréation (vente de gamètes et maternité de substitution à titre onéreux).

Notre document comporte quatre chapitres. Les deux premiers traitent des aspects médicaux et juridiques de la procréatique, et les deux autres portent respectivement sur le rôle de l'État en la matière et les réformes que propose la Commission.

Plus précisément, le premier chapitre explique le processus de la conception, les différentes formes de l'infertilité et les techniques les plus souvent utilisées pour y remédier. Nous y discuterons également des indications génétiques qui peuvent motiver le recours à certaines de ces techniques, ainsi que des risques et des conséquences qui s'y rattachent. Une attention particulière sera portée aux taux de succès, aux différentes façons de les déterminer et à leurs effets sur l'aptitude des couples infertiles à choisir la technique qui leur convient le mieux. Enfin, ce chapitre explique les différents procédés utilisés pour le don de gamètes, ainsi que l'importance de la sélection des donneurs.

Le deuxième chapitre expose les interrogations du droit canadien devant les diverses situations que la procréatique a rendues possibles, tant au point de vue des règles du droit privé qu'à celui des droits garantis par la *Charte canadienne des droits et libertés*[10]. Les principales questions étudiées au titre du droit privé ont trait à la nature juridique des gamètes et des embryons, à la filiation des enfants nés de la procréatique, à la responsabilité des donneurs de gamètes, à celle des banques de gamètes et d'embryons et à celle des médecins, à la nature du contrat de maternité de substitution, et à l'application des principes de droit en matière de commercialisation du corps, de ses produits et de ses substances. D'autre part, nous examinerons l'incidence de la Charte sur la réglementation par l'État du recours à la procréatique. Dans cette perspective, nous nous interrogerons sur l'existence et les limites d'un éventuel droit constitutionnel à la procréation, et sur l'incidence des droits à l'égalité sur la réglementation de l'accès à la procréatique. Nous conclurons par de brèves remarques sur l'application de l'article premier de la Charte dans ce contexte.

Dans le but de déterminer la nécessité et l'étendue d'une intervention étatique éventuelle dans le domaine de la procréation médicalement assistée, nous verrons au chapitre trois les mécanismes de réglementation existants, leur portée, ainsi que le rôle de l'État en la matière.

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10. Partie I de la *Loi constitutionnelle de 1982* [annexe B de la *Loi de 1982 sur le Canada* (1982, R.-U., ch. 11)].

À la lumière des analyses contenues dans les chapitres qui le précèdent, le chapitre quatre énonce une série de propositions de réforme destinées à mieux définir les intérêts en cause, à préciser les droits et les obligations des personnes touchées par le recours à la procréatique et à réaliser l'équilibre nécessaire entre les diverses valeurs en présence telles que le respect de la dignité humaine et le respect des droits et des libertés individuels des intéressés. Nos propositions débouchent sur l'instauration d'un mécanisme de mise en œuvre de nos recommandations.

Le lecteur trouvera à l'annexe A une description des différentes mesures recommandées ou adoptées dans ce domaine à l'étranger — notamment en Australie, au Danemark, en Espagne, au Conseil de l'Europe, aux États-Unis, en France, en Norvège, au Royaume-Uni, en Suède et en Allemagne —, dans les provinces canadiennes de common law et au Québec. À l'annexe B, enfin, nous proposons une ébauche de la structure que pourrait prendre un texte de loi réglementant les principaux aspects de la procréation médicalement assistée.

Nous reconnaissons que bon nombre de questions soulevées dans cette étude relèvent de la compétence des provinces. Mais comme elles mettent en cause la santé publique, la protection de certaines valeurs fondamentales de notre société, la protection de la vie humaine et de l'intégrité physique, le commerce international et interprovincial, certains droits garantis par la *Charte canadienne des droits et libertés* et un besoin criant d'uniformisation, nous croyons que le fédéral peut et doit jouer un rôle catalyseur important dans la recherche et l'élaboration d'une politique canadienne.

CHAPITRE PREMIER

Données d'ordre médical

De nos jours, environ 15 pour 100 des couples demandent une aide médicale pour résoudre des problèmes de fertilité[11]. Il n'est pas certain que cela reflète une augmentation des cas d'infertilité au cours des ans. Ce qui est certain, en revanche, c'est que l'adoption d'enfants en bas âge devient de plus en plus difficile et ne peut plus être considérée comme la solution à l'infécondité qu'elle représentait autrefois[12]. Plus l'adoption est devenue difficile, plus le recours à la procréatique et aux traitements médicaux contre l'infertilité s'est répandu. Dans ce premier chapitre, nous expliquerons brièvement en quoi consiste l'infertilité et quelles sont les techniques de procréation les plus fréquemment utilisées pour y remédier, notamment la fécondation in vitro (FIV), l'implantation tubaire de gamètes (GIFT[13]) et l'insémination artificielle.

Il est clair que certaines techniques ont une plus grande valeur thérapeutique que d'autres. L'aptitude des couples infertiles à choisir la technique qui leur convient le mieux pouvant être compromise par des rapports contradictoires sur les succès obtenus avec les différentes techniques, nous analyserons en détail ces taux de succès. Nous expliquerons aussi le processus du don de gamètes (spermatozoïdes et ovules), de même que l'importance de prévenir, par une sélection adéquate des donneurs, la transmission de maladies infectieuses et génétiques graves.

I. Le mécanisme de la conception

Au cours de sa vie active, l'homme produit continuellement des spermatozoïdes. L'éjaculat contient souvent plus de 100 millions de spermatozoïdes par millilitre, ce qui contraste vivement avec les 400 ou 500 ovules produits par la femme entre la puberté et la ménopause, normalement un à la fois, une fois par mois.

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11. SOCIÉTÉ CANADIENNE DE FERTILITÉ ET D'ANDROLOGIE, *Insémination thérapeutique avec sperme de donneur*, Montréal, la Société, 1988, p. 9.

12. CRDO, *op. cit.*, note 2, p. 16. On y discute de la réduction du nombre de nouveau-nés disponibles pour adoption en Ontario. Par exemple, en 1982, 73 jeunes enfants ont été donnés en adoption, comparativement à 961 en 1969.

13. Certaines techniques de procréation assistée sont à l'heure actuelle couramment désignées au moyen de sigles ou d'acronymes anglais, même en français ; voir notamment Jan TESARIK et Jacques TESTART, « La fécondation » (1989), 20 *La Recherche* 1008, 1010 et passim. Nous avons cru utile, afin d'aider le lecteur à s'y retrouver, de reproduire ces sigles et acronymes anglais lorsqu'ils sont d'usage courant.

Chez la femme ayant atteint la maturité génitale, plusieurs ovocytes (gamètes femelles non arrivés à maturité) commencent à se développer chaque mois dans les ovaires. Normalement, un seul parvient à maturité. Une structure appelée follicule abrite et nourrit l'ovocyte jusqu'à ce qu'il arrive à maturité sous l'influence cyclique des hormones libérées par l'hypophyse. Lors de l'ovulation, le follicule libère l'ovule entouré de ses enveloppes. Le follicule reste actif après l'ovulation et sécrète les hormones (la progestérone et l'estrogène) nécessaires pour préparer la muqueuse utérine (l'endomètre) à l'implantation.

La conception dépend d'une série d'événements qui doivent être bien synchronisés. D'abord, les spermatozoïdes doivent être déposés en nombre suffisant dans le vagin ; ils doivent en outre être dotés d'une motilité adéquate pour traverser le vagin, l'utérus et les trompes de Fallope non obstruées, et aller ainsi à la rencontre de l'ovule libéré par l'ovaire[14].

L'ovule est susceptible de fécondation pendant environ vingt-quatre heures, après quoi il meurt. La longévité approximative du spermatozoïde est de quarante-huit heures (la fécondation peut cependant avoir lieu jusqu'à trois jours ou plus après l'insémination)[15]. Par conséquent, la conception n'est possible que pendant quelques jours chaque mois au cours du cycle menstruel.

La fécondation commence par le contact du spermatozoïde et de l'ovule, et se termine par l'union des chromosomes maternels et paternels (les pronuclei mâle et femelle). Elle a lieu dans le tiers distal de la trompe de Fallope. La cellule produite par l'union des pronuclei mâle et femelle est appelée zygote ; son bagage génétique est déjà différent de ceux de la mère et du père dont elle est issue.

La première division cellulaire se produit environ trente heures après la fécondation et se poursuit tandis que le zygote continue sa migration dans la trompe. Environ trois jours après la fécondation, l'embryon entre dans l'utérus ; il est alors constitué de seize cellules. L'implantation dans la paroi utérine — ou nidation — a lieu entre le sixième et le dixième jour après la fécondation. L'embryon est maintenant une boule de cellules creuse connue sous le nom de « blastocyste[16] ».

Relativement peu d'embryons franchissent cette étape. L'on évalue en effet à plus de 60 pour 100 le taux des embryons perdus avant la douzième semaine de grossesse, et 90 pour 100 de ces pertes se produisent, à l'insu de la mère, avant l'interruption du cycle menstruel[17]. Le taux d'avortement clinique spontané dans la population en général

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14. Pour un examen complet de cette question, voir Keith L. Moore, *Before We Are Born: Basic Embryology and Birth Defects*, 3e éd., Philadelphie, W.B. Saunders, 1989, ch. II et III.

15. La migration à travers l'utérus et les trompes de Fallope déclenche un processus appelé capacitation, qui constitue l'étape finale de la maturation du spermatozoïde. La capacitation est essentielle au succès de la fécondation.

16. Keith L. Moore, *The Developing Human: Clinically Oriented Embryology*, 4e éd., Philadelphie, W.B. Saunders, 1988, pp. 27-35.

17. D. Keith Edmonds, Kevin S. Lindsay, John F. Miller et autres, « Early Embryonic Mortality in Women » (1982), 38:4 *Fertil. Steril.* 447.

est d'environ 15 pour 100[18]. Environ 50 à 60 pour 100 de ces fausses-couches sont dues à des anomalies chromosomiques, résultat de gamètes imparfaits ou d'une fécondation anormale. Ainsi, l'avortement spontané constitue dans une large mesure une forme de protection naturelle contre la poursuite d'une grossesse anormale[19].

Par conséquent, dans un groupe donné de 100 femmes qui ovulent et conçoivent effectivement un enfant, seulement 25 auront conscience de leur grossesse ; parmi celles-ci, à peu près 4 avorteront et 21 mettront au monde un bébé vivant. Voilà pourquoi les humains sont considérés comme des procréateurs inefficaces. Et comme nous le verrons, ce manque d'aptitude est l'un des problèmes les plus insolubles de la procréation médicalement assistée.

II. L'infertilité

L'infertilité consiste dans la réduction involontaire importante de la capacité de procréer. En Amérique du Nord, elle est généralement définie comme l'impossibilité de concevoir après un an de relations sexuelles sans contraception[20]. La norme appliquée par l'Organisation mondiale de la santé est de deux ans[21].

Quoique les études canadiennes sur la fréquence de l'infertilité soient rares, on reconnaît — nous l'avons vu — que 15 pour 100 des couples consultent un médecin pour ce motif[22]. Aux États-Unis, la fréquence de l'infertilité a peu évolué : de 13,3 pour 100 en 1965, elle est passée à environ 13,9 pour 100 en 1982, compte non tenu de la stérilisation chirurgicale volontaire[23].

Voici quelques-uns des facteurs qui influent sur la fréquence de l'infertilité[24] : (1) la tendance aux grossesses tardives[25] ; (2) les facteurs extérieurs comme l'infection résultant des maladies transmises sexuellement et les facteurs liés au milieu de travail ; (3) les

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18. *Ibid.* Cette proportion varie selon l'âge. Pour une explication de ce qu'est l'avortement spontané, voir *infra*, p. 17.

19. K.L. Moore, *op. cit.*, note 14, p. 34.

20. Mary G. Hammond, « Evaluation of the Infertile Couple » (1987), 14:4 *Obstet. Gynecol. Clin. N. Am.* 821.

21. M.A. Belsey et Helen Ware, « Epidemiological, Social and Psychosocial Aspects of Infertility », dans Vaclav Insler et Bruno Lunenfeld (dir.), *Infertility: Male and Female*, Édimbourg, Churchill Livingstone, 1986, p. 631, à la page 632.

22. Société canadienne de fertilité et d'andrologie, *op. cit.*, note 11, p. 9.

23. Congress of the United States, Office of Technology Assessment (ci-après OTA), *Infertility: Medical and Social Choices*, Washington (D.C.), OTA, 1988, pp. 51-52.

24. Pour un examen de la question de la prévention de l'infertilité, voir Masood A. Khatamee, « Infertility: A Preventable Epidemic? » (1988), 33:4 *Int. J. Fertil.* 246. De plus, pour un examen des facteurs qui influencent l'infertilité, voir *Infertility: Medical and Social Choices*, *op. cit.*, note 23, pp. 61-82.

25. Pour des statistiques sur la tendance des Canadiennes à retarder l'âge de la grossesse, voir A. Romaniuc, *La fécondité au Canada : Croissance et déclin*, Ottawa, Statistique Canada, 1984, pp. 29-35. En outre, il a été établi que la fréquence de l'infertilité est environ 10 pour 100 plus élevée chez les femmes de plus de 35 ans : *Infertility: Medical and Social Choices*, *op. cit.*, note 23, p. 52.

traitements médicaux comme ceux qui sont utilisés dans les cas d'hypertension artérielle, d'ulcères gastriques et de cancer, de même que les drogues non thérapeutiques comme les stupéfiants, l'alcool et le tabac[26].

A. L'évaluation du couple infertile

Le couple infertile qui s'adresse à un médecin est soumis à une série d'examens pour établir la nature et la gravité du problème. Le médecin procède d'abord à un interrogatoire sur les antécédents médicaux des partenaires et, si besoin est, conseillera le couple sur les conditions propices aux rapports sexuels efficaces[27].

La femme devra d'abord se soumettre à des examens visant à déceler toute dysfonction hormonale. On pratiquera ensuite une biopsie de la muqueuse utérine et une hystérosalpingographie, c'est-à-dire une radiographie qui révélera l'obstruction éventuelle des trompes de Fallope. La laparoscopie, soit l'introduction d'un endoscope à l'intérieur de l'abdomen, permet d'examiner les surfaces externes de l'utérus, des trompes et des structures avoisinantes, afin de déceler toute anomalie. Ces examens sont souvent douloureux et comportent de légers risques d'infection ; ils peuvent même provoquer la perforation de l'utérus, encore que le cas soit rare. Des précautions médicales, telle l'administration d'antibiotiques, contribuent à réduire ces risques[28].

Chez l'homme, un spermogramme est nécessaire pour évaluer la concentration et la qualité du sperme. Si le sperme est anormal, on peut procéder à des analyses sanguines pour déceler toute anomalie hormonale[29]. Une analyse post-coïtale peut également servir à révéler toute incompatibilité entre le sperme et les facteurs de reproduction de la femme. Cet examen exige que le couple ait des rapports sexuels au moment de l'ovulation ; l'analyse post-coïtale de la glaire cervicale doit être effectuée dans les quelques heures qui suivent[30].

B. Les causes et les traitements de l'infertilité

L'infertilité peut être attribuable à l'un des partenaires, aux deux ou à une incompatibilité biochimique ou immunologique entre eux. Dans la plupart des cas, l'infertilité

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26. R.J. Sobel, Y. Liel et S.M. Glick, « Medical Conditions Leading to Infertility », dans V. Insler et B. Lunenfeld (dir.), *op. cit.*, note 21, p. 673, aux pages 677-681.

27. M.G. Hammond, *loc. cit.*, note 20, 821-827.

28. Pour une étude plus approfondie de ce sujet, voir Leon Speroff, Robert H. Glass et Nathan G. Kase, *Clinical Gynecologic Endocrinology and Infertility*, 4e éd., Baltimore, Williams & Wilkins, 1989, ch. XVII.

29. Des études répétées chez des hommes fertiles ont démontré une grande variabilité du décompte spermatique avec le temps, soulignant le fait qu'il est souvent nécessaire d'effectuer au moins deux ou trois décomptes pour obtenir un nombre exact. Voir Richard F. Spark, *The Infertile Male: The Clinician's Guide to Diagnosis and Treatment*, New York, Plenum, 1988, p. 130. Voir aussi David W. Keller, Ronald C. Strickler et James C. Warren, *Clinical Infertility*, Norwalk (Conn.), Appleton-Century-Crofts, 1984, p. 100.

30. M.G. Hammond, *loc. cit.*, note 20, 826.

féminine est causée par l'un des facteurs suivants : une dysfonction ovulatoire, habituellement en raison d'une anomalie hormonale, une obstruction tubaire[31] résultant d'une infection ou de tout autre processus morbide, l'endométriose[32], d'autres causes, y compris les anomalies du vagin ou du col utérin et l'incompatibilité glaireuse avec le sperme[33].

Le traitement de l'infertilité féminine comprend : le traitement hormonal ou médicamenteux, la chirurgie, les techniques de procréation médicalement assistée comme la fécondation in vitro ou l'implantation tubaire de gamètes.

L'infertilité pour cause de dysfonction ovulatoire est traitée au moyen de stimulants ovulatoires, qui sont très efficaces si la dysfonction est la seule cause de l'infertilité[34]. D'autres médicaments servent à traiter l'endométriose, les infections et les incompatibilités immunitaires. En cas d'obstruction des trompes de Fallope, la chirurgie peut être indiquée[35]. Lorsque les autres traitements contre l'infertilité ont échoué, il est possible de recourir à la procréatique, qui constitue cependant une solution de dernier recours.

Les causes habituelles de l'infertilité masculine sont les suivantes : concentration faible ou nulle des spermatozoïdes dans le liquide spermatique, motilité anormale des spermatozoïdes, anomalies de structure. Toutes empêchent la fécondation normale de l'ovule. La cause précise de l'infertilité masculine est souvent impossible à déceler, mais la varicocèle (ou varices des testicules) ou l'infection peuvent en être responsables[36]. La

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31. Peter McComb, Victor Gomel et Timothy Rowe, « Investigation of Tuboperitoneal Causes of Female Infertility », dans V. Insler et B. Lunenfeld (dir.), *op. cit.*, note 21, p. 213.

32. Dans le cas de l'endométriose, le tissu qui tapisse l'utérus, appelé endomètre, se développe anormalement à l'extérieur de l'utérus. Environ 10 pour 100 des femmes en préménopause souffrent d'endométriose et à peu près 30 pour 100 des femmes atteintes sont infertiles. Le mécanisme exact de cette forme d'infertilité est inconnu. Voir Ken Muse, « Clinical Manifestations and Classification of Endometriosis » (1988), 31:4 *Clin. Obstet. Gynecol.* 813.

33. K.S. Moghissi, « Diagnosis and Classification of Disturbed Sperm-Cervical Mucus Interaction », dans V. Insler et B. Lunenfeld (dir.), *op. cit.*, note 21, p. 299.

34. Janet L. Kennedy et Eli Y. Adashi, « Ovulation Induction » (1987), 14:4 *Obstet. Gynecol. Clin. N. Am.* 821, 838-844. Voir *infra*, pp. 14-15 et note 56, pour un examen des risques communément courus. Les risques de grossesse multiple se situent entre 6 et 12 pour 100 avec l'usage de clomifène et entre 4 et 18 pour 100 si l'on utilise des gonadotrophines humaines de femmes ménopausées (Pergonal®). La probabilité de provoquer un « syndrome d'hyperstimulation » est plus élevée avec le Pergonal® qu'avec le clomifène. La gravité de ce syndrome varie : les femmes légèrement atteintes (15 pour 100) souffrent d'hypertrophie des ovaires alors que celles gravement atteintes (1 pour 100) souffrent de problèmes du métabolisme hydrique, qui peuvent être graves au point de provoquer un état de choc. Les ovaires peuvent s'hypertrophier jusqu'à la rupture, rendant nécessaire leur ablation ; l'on a même rapporté, quoique très rarement, des cas de décès. L'utilisation de certains stimulants ovulatoires exige donc une surveillance médicale serrée. Voir aussi Richard Borenstein et autres, « Severe Ovarian Hyperstimulation Syndrome: A Reevaluated Therapeutic Approach » (1989), 51:5 *Fertil. Steril.* 791.

35. Pour une description des indications et des taux de succès et une analyse des coûts, consulter : Ricardo Marana et John Quagliarello, « Distal Tubal Occlusion: Microsurgery versus In Vitro Fertilization — A Review » (1988), 33:2 *Int. J. Fertil.* 107. Voir aussi, par les mêmes auteurs, « Proximal Tubal Occlusion: Microsurgery versus IVF — A Review » (1988), 33:5 *Int. J. Fertil.* 338, 338-340.

36. R.F. Spark, *op. cit.*, note 29, pp. 129-133.

production déficiente de spermatozoïdes ou l'obstruction des conduits séminaux peuvent entraîner l'absence de spermatozoïdes (azoospermie). Quoique la présence d'un nombre très réduit de spermatozoïdes (oligospermie) diminue la fertilité, le nombre de spermatozoïdes nécessaire aux fonctions normales de reproduction demeure controversé[37].

Lorsque le décompte spermatique est inférieur à cinq millions, la fertilité est considérablement réduite[38]. Par conséquent, le couple qui n'est pas prêt à attendre le nombre d'années souvent nécessaire pour concevoir un enfant « naturellement » peut avoir recours aux traitements contre l'hypofertilité masculine. Ceux-ci comprennent l'hormonothérapie et des techniques de laboratoire comme celle du « spermatozoïde surnageant[39] », qui visent à augmenter la concentration de spermatozoïdes normaux pour la fécondation. Le succès de ces techniques dans le cadre de l'insémination artificielle est cependant inférieur à 20 pour 100[40].

L'on pourrait en théorie s'attendre à ce que la fécondation in vitro soit utile dans les cas d'hypofertilité masculine. Une fois l'ovule placé en contact direct avec le sperme du partenaire, les spermatozoïdes normaux, même s'ils sont relativement peu nombreux, devraient être capables de le féconder. Le couple aurait alors un enfant lié génétiquement aux deux parents. Il semble cependant que la capacité du spermatozoïde de féconder l'ovule soit deux fois moins élevée que dans les cas de fécondation in vitro non reliés à des facteurs masculins[41]. Pourtant, certains rapports montrent que la fécondation in vitro est aussi efficace dans des cas d'infertilité causée par des facteurs reliés à l'homme que par d'autres facteurs[42]. Quoi qu'il en soit, l'insémination artificielle avec sperme de donneur constitue le remède le plus intéressant à la fois pour l'homme infertile et pour l'homme stérile, puisqu'elle est moins coûteuse, moins agressive et, selon les statistiques, beaucoup plus efficace que la fécondation in vitro[43].

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37. *Ibid.* Bien qu'un décompte spermatique inférieur à dix millions soit considéré comme trop faible, certaines grossesses se sont produites chez les partenaires d'hommes dont le décompte spermatique était inférieur à cinq millions (*id.*, p. 129).

38. Erik BOSTOFTE, Jorgen SERUP et Heinrich REBBE, « Hammen Semen Quality Classification and Pregnancies Obtained during a Twenty-Year Follow-up Period » (1981), 36:1 *Fertil. Steril.* 84.

39. La technique du « spermatozoïde surnageant » a pour but d'obtenir la concentration la plus élevée possible de spermatozoïdes mobiles en recueillant les spermatozoïdes placés dans un récipient et ayant nagé jusqu'à la surface d'un milieu spécial. Nancy J. ALEXANDER et Steven ACKERMAN, « Therapeutic Insemination » (1987), 14:4 *Obstet. Gynecol. Clin. N. Am.* 905, 909.

40. N.J. ALEXANDER et S. ACKERMAN, *loc. cit.*, note 39, 911. Une analyse de la littérature faisant état de 812 cas d'infertilité masculine traités par l'insémination artificielle à partir du sperme du mari a donné comme résultat un taux de grossesse de 18 pour 100.

41. N.J. ALEXANDER et S. ACKERMAN, *loc. cit.*, note 39, 913. Voir aussi A. ACOSTA et autres, « The Role of In Vitro Fertilization in Male Infertility » (1988), 541 *Ann. N.Y. Acad. Sci.* 297, 301, et Irvin HIRSCH et autres, « In Vitro Fertilization in Couples with Male Factor Infertility » (1986), 45:5 *Fertil. Steril.* 659, 662.

42. Dans des groupes sélectionnés de cas d'infertilité masculine, la fécondation in vitro a connu un succès comparable à celui obtenu dans d'autres cas d'infertilité ; voir I. HIRSCH et autres, *loc. cit.*, note 41, 663.

43. N.J. ALEXANDER et S. ACKERMAN, *loc. cit.*, note 39, 918 et suiv.

III. Les indications génétiques de la procréatique

Les individus qui ne sont pas infertiles mais risquent de transmettre des maladies ou des anomalies génétiques graves[44] peuvent, de ce fait, être considérés comme candidats à la procréatique. La personne à risque peut avoir besoin du don de l'un ou des deux gamètes si la maladie dont elle porte le gène ne peut être décelée avant la naissance ou si le couple est opposé à l'avortement thérapeutique pour le cas où le fœtus serait atteint. Les maladies génétiques pouvant être transmises à l'enfant sont de trois types : les maladies à caractère autosomique récessif, comme la maladie de Tay-Sachs ou la thalassémie[45] ; les maladies liées au chromosome X, comme la myopathie de Duchenne ou l'hémophilie[46] ; les maladies à caractère autosomique dominant, comme la chorée de Huntington[47]. La présence d'anomalies chromosomiques (de structure ou de nombre) peut aussi présenter un risque important pour l'enfant.

IV. Les techniques de procréation médicalement assistée

A. La fécondation in vitro (FIV)

Les premières tentatives de fécondation in vitro ont eu lieu en 1878 sur des lapins et des cobayes. Cent ans plus tard naissait le premier « bébé-éprouvette[48] ». Depuis ce temps, plus de trois mille enfants ont vu le jour dans le monde grâce à la fécondation in vitro[49]. Cette technique est utilisée le plus fréquemment dans les cas d'obstruction des trompes de Fallope, mais elle sert aussi dans certains cas d'endométriose, d'infertilité masculine ou d'infécondité inexpliquée[50].

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44. Prises individuellement, les maladies génétiques sont en général assez rares ; collectivement, par contre, elles constituent plus de 30 pour 100 de toutes les admissions dans les hôpitaux pédiatriques. Judith G. HALL, « Impact of Genetic Disease on Pediatric Health Care », dans M.M. KABACK et L.J. SHAPIRO (dir.), *Frontiers in Genetic Medicine: Report on the 92nd Ross Conference in Pediatric Research*, Columbia (Ohio), Ross Laboratory 1981, p. 1, à la page 1.

45. Dans le cas d'une maladie à caractère autosomique récessif, l'enfant n'est exposé à la maladie que lorsque les deux parents sont porteurs du gène. Il n'en sera atteint que lorsque chacun d'eux lui transmet le gène récessif en question. Le risque que l'enfant soit atteint est de 25 pour 100 pour chaque grossesse.

46. Ces maladies sont aussi appelées maladies liées au sexe. Le gène de la maladie est situé sur le chromosome X ; il est transmis dans la plupart des cas par une mère non atteinte (qui a deux chromosomes X) à son fils (qui a un chromosome X et un chromosome Y). Pour chaque fils, les risques d'hériter de la maladie sont de 50 pour 100, et pour chaque fille, les risques d'hériter du gène de la maladie et d'en devenir porteuse, généralement sans être elle-même atteinte sont aussi de 50 pour 100.

47. Si l'un des parents est porteur du gène de la maladie, les risques de contracter la maladie sont de 50 pour 100 pour chaque enfant.

48. S. FISHEL, « IVF — Historical Perspective », dans S. FISHEL et E.M. SYMONDS (dir.), *In Vitro Fertilisation: Past, Present, Future*, Oxford, IRL Press, 1986, p. 1, aux pages 1-16.

49. Machelle M. SEIBEL, « A New Era in Reproductive Technology » (1988), 318:13 *New Engl. J. Med.* 828.

50. *Id.*, 828, 829.

La fécondation in vitro implique par définition la fécondation d'un ovule à l'extérieur du corps de la future mère, c'est-à-dire en laboratoire. La technique consiste à retirer de l'ovaire les oeufs arrivés à maturité, à les faire féconder dans un contenant et à implanter les embryons dans l'utérus dès le début de leur développement.

Le processus comporte cinq étapes : (1) l'administration de médicaments pour stimuler l'ovulation ; (2) la ponction d'un ou de plusieurs ovocytes arrivés à maturité ; (3) la fécondation d'un ou de plusieurs de ces ovules à l'extérieur du corps ; (4) l'incubation du ou des ovules fécondés jusqu'à ce qu'ils soient prêts à être implantés ; (5) l'implantation des embryons dans l'utérus dès le début de leur développement[51]. Le succès de chaque étape dépend de la précédente. En cas d'échec, quelle que soit l'étape à laquelle il survient, il n'y a pas de grossesse.

1. La stimulation ovarienne

La probabilité d'une grossesse et, éventuellement, d'une naissance vivante augmente lorsque trois ou quatre embryons sont implantés simultanément dans l'utérus. Par conséquent, dans presque tous les programmes de fécondation in vitro qui ont cours dans le monde, on utilise des médicaments qui, pris seuls ou en combinaison avec d'autres, entraînent la production et la maturation de plus d'un ovocyte par cycle[52].

La stimulation ovarienne réussit dans environ 80 pour 100 des cas (on appelle « cycle annulé » la stimulation infructueuse)[53]. Pendant le traitement, la patiente est hospitalisée ou vue en clinique externe, de façon que l'on puisse mesurer fréquemment le taux hormonal par des prélèvements sanguins et surveiller au moyen de l'échographie le développement des follicules[54].

Les effets secondaires habituels des médicaments inducteurs de l'ovulation comprennent : les bouffées de chaleur (10 pour 100), la distension abdominale avec douleur (5,5 pour 100), les malaises mammaires (2 pour 100), les troubles visuels (1,5 pour 100), les céphalées (1,3 pour 100) et la perte des cheveux (0,3 pour 100)[55]. Le « syndrome

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51. THE REPRODUCTIVE ENDOCRINOLOGY AND FERTILITY COMMITTEE, SOCIÉTÉ DES OBSTÉTRICIENS ET GYNÉCOLOGUES DU CANADA, « In Vitro Fertilization and Embryo Transfer in Canada » (1987), 9:3 *SOGC Bulletin* 15, 16-17 (ci-après *IVF-ET Canada*).

52. Les médicaments les plus utilisés sont le citrate de clomifène (Clomid®), les gonadotrophines humaines de femmes ménopausées (Pergonal®) et les gonadotrophines chorioniques humaines. *IVF-ET Canada*, *loc. cit.*, note 51, 16. Gary D. HODGEN, « Physiology of Follicular Maturation », dans Howard W. JONES, Jr., *In Vitro Fertilization — Norfolk*, Baltimore, Williams & Wilkins, 1986, p. 8, à la page 9. Voir aussi I.T. CAMERON et D.L. HEALY, « Patient Management », dans Carl WOOD et Alan TROUNSON (dir.), *Clinical In Vitro Fertilization*, 2e éd., Londres, Springer-Verlag, 1989, p. 11, à la page 15. Au sujet des risques inhérents à l'usage de ces médicaments, voir *supra*, note 34.

53. I.T. CAMERON et D.L. HEALY, *loc. cit.*, note 52, 15.

54. G.T. KOVACS, « Selection and Preparation of Patients for In Vitro Fertilization », dans C. WOOD et A. TROUNSON (dir.), *op. cit.*, note 52, p. 1, à la page 2.

55. J.L. KENNEDY et E.Y. ADASHI, *loc. cit.*, note 34, 838. Voir aussi L. SPEROFF, R.H. GLASS et N.G. KASE, *op. cit.*, note 28, p. 591.

d'hyperstimulation » survient rarement lors d'essais de fécondation in vitro. On peut réduire au minimum la fréquence de ce syndrome grâce à des précautions médicales, entre autres l'évacuation de tous les follicules, l'examen fréquent des ovaires par échographie et le contrôle des niveaux hormonaux dans le sang[56].

2. Le prélèvement d'ovocytes

Le prélèvement des ovocytes (arrivés à maturité) se fait par laparoscopie ou échographie. Dans le premier cas, la paroi abdominale est perforée et l'abdomen rempli d'un mélange gazeux, ce qui crée un espace entre cette paroi et les organes intraabdominaux. On insère alors dans l'espace un ou plusieurs tubes, dont un endoscope, pour que le chirurgien puisse observer et manipuler les ovaires sans avoir à pratiquer une trop large incision. Les ovocytes mûrs sont alors extraits des follicules. Le principal inconvénient de la laparoscopie est qu'elle exige une anesthésie générale, en plus de l'administration de plusieurs médicaments pendant et après l'intervention afin de maintenir l'effet de l'anesthésique et soulager la douleur. Les effets de ces médicaments sur la grossesse ont causé quelque inquiétude, puisque l'on sait qu'ils peuvent pénétrer le liquide folliculaire. Quoi qu'il en soit, les études effectuées jusqu'à maintenant ne démontrent aucun effet manifeste sur le résultat de la grossesse[57].

Le prélèvement par échographie est plus avantageux que le précédent parce qu'il est moins douloureux et qu'il ne nécessite pas d'anesthésie générale[58]. L'échographie consiste dans l'irradiation, de l'extérieur du corps, d'ondes sonores de haute énergie qui permettent de reproduire l'image des organes et des structures internes[59]. Au moyen de l'image ultrasonique de l'ovaire, le chirurgien guide une aiguille dans les follicules, soit par le vagin, soit par l'urètre ou soit par la paroi abdominale[60]. Les ovocytes arrivés à maturité sont alors aspirés à l'extérieur de l'ovaire.

Les méthodes de laparoscopie et d'échographie sont comparables du point de vue du nombre et de la qualité des oeufs recueillis. L'on prélève en moyenne quatre ovocytes par cycle, mais l'ovaire peut en produire jusqu'à vingt[61].

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56. Daniel NAVOT et autres, « Risk Factors and Prognostic Variables in the Ovarian Hyperstimulation Syndrome » (1988), 159:1 *Am. J. Obstet. Gynecol.* 210, 214. Voir aussi I.T. CAMERON et D.L. HEALY, *loc. cit.*, note 52, 15. Pour une description du syndrome, voir la note 34, *supra*.

57. J. WEBSTER, « Laparoscopic Oocyte Recovery », dans S. FISHEL et E.M. SYMONDS (dir.), *op. cit.*, note 48, p. 69. Voir aussi J. LEETON, « Oocyte Pick-up », dans C. WOOD et A. TROUNSON (dir.), *op. cit.*, note 52, p. 23, à la page 24.

58. J. LEETON, *loc. cit.*, note 57, 24.

59. Lucy Frank SQUIRE et Robert A. NOVELLINE, *Fundamentals of Radiology*, 4e éd., Cambridge, Harvard University, 1988, p. 27.

60. Les techniques qui consistent à traverser la vessie pleine pour arriver à l'ovaire sont les plus douloureuses et l'anesthésie locale n'apporte alors qu'un léger soulagement. J. LEETON, *loc. cit.*, note 57, 25.

61. P. DELLENBACH et autres, « The Transvaginal Method for Oocyte Retrieval » (1988), 541 *Ann. N.Y. Acad. Sci.* 111.

Les risques inhérents à l'anesthésie générale font partie, lorsqu'elle est utilisée, des risques médicaux entourant la ponction d'ovocytes. Par ailleurs, il existe aussi des risques de saignement vaginal, de douleur, d'infection pelvienne[62] et de perforation accidentelle de vaisseaux sanguins. On a rapporté au moins un cas de décès résultant d'une hémorragie non décelée à la suite d'un prélèvement d'ovocytes[63].

3. L'évaluation des ovocytes, la fécondation et le transfert de l'embryon

La qualité et la maturité des ovocytes prélevés sont évaluées au microscope, afin d'augmenter les chances d'une fécondation normale. L'échantillon de sperme aura déjà été soumis à une évaluation et à une préparation semblables. Le sperme est ensuite placé dans la boîte ou l'éprouvette qui contient les ovocytes[64].

Si la fécondation réussit, les embryons sont placés en incubateur. Cela provoque, dans un délai d'environ quarante-quatre heures, la division cellulaire jusqu'au stade de quatre cellules. Les embryons sont ensuite implantés dans l'utérus entre les stades de quatre et de huit cellules, après quoi la femme reçoit son congé de l'hôpital et est habituellement encouragée à reprendre un rythme de vie normal[65].

4. Les taux de succès

Les critères pouvant varier d'une clinique à l'autre, il est difficile d'évaluer le succès de la fécondation in vitro. Parmi ces critères, on retrouve le nombre de grossesses « chimiques », « cliniques » ou « viables », qui peut être calculé sur la base du nombre de « cycles de traitement », de « prélèvements d'ovocytes », de « transferts d'embryon » ou de « femmes traitées ». Les nombreuses combinaisons des critères de « succès » sont sources de confusion. Pour clarifier la situation, il est indispensable de comprendre la définition de chacun des « numérateurs » et « dénominateurs » possibles[66].

5. La détermination du numérateur

On entend par grossesse « chimique » une grossesse susceptible d'être détectée par des méthodes biochimiques (épreuve à la gonadotrophine chorionique), mais qui ne dure

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62. Selon les rapports existants, l'infection pelvienne, qui peut être grave, survient dans environ 3 pour 100 des cas ; ce pourcentage peut être réduit par l'administration d'antibiotiques ; voir Robert S. Howe et autres, « Pelvic Infection after Transvaginal Ultrasound-Guided Ovum Retrieval » (1988), 49:4 *Fertil. Steril.* 726, 728.

63. M.M. Seibel, *loc. cit.*, note 49, 829-830.

64. La concentration des spermatozoïdes utilisée est beaucoup plus grande que celle que rencontre normalement l'ovule dans les trompes ; A. Trounson, « Fertilization and Embryo Culture », dans C. Wood et A. Trounson (dir.), *op. cit.*, note 52, p. 33, aux pages 33-47.

65. M.M. Seibel, *loc. cit.*, note 49, 830-831. Voir aussi *IVF-ET Canada*, *loc. cit.*, note 51, 17.

66. Hilary Page, « Calculating the Effectiveness of In-Vitro Fertilization: A Review » (1989), 96:3 *Br. J. Obstet. Gynaecol.* 334 ; A. Albert Yuzpe et autres, « Rates and Outcome of Pregnancies Achieved in the First 4 Years of an In-Vitro Fertilization Program » (1989), 140:2 *Journal de l'Association médicale canadienne* 167, 168.

pas assez longtemps pour retarder de plus de quatorze jours les menstruations (on parle alors d'avortement préclinique). La grossesse ne peut être décelée par des méthodes cliniques, aucun tissu identifiable n'est éliminé et aucune intervention médicale n'est requise[67].

La « grossesse clinique » est celle qui se poursuit au-delà du vingt-huitième jour après le prélèvement de l'ovule ; elle peut être décelée à la fois par des méthodes biochimiques et par l'échographie[68]. Cela suppose que l'embryon s'est implanté et que la grossesse peut maintenant être assimilée à une grossesse naturelle. La grossesse est considérée comme « clinique » jusqu'à ce que le fœtus ait franchi le cap de la viabilité. Si la grossesse clinique est interrompue, on parle d'avortement spontané ou de fausse-couche. Une intervention médicale peut être nécessaire.

Enfin, et quoique la définition de la viabilité puisse varier d'un pays à l'autre, on considère habituellement que la grossesse est « viable » à compter de la vingt-deuxième semaine qui suit les dernières menstruations[69]. Le fœtus est alors jugé apte à survivre seul à l'extérieur du corps de sa mère.

Le nombre de naissances vivantes constitue probablement le critère de succès le plus important, et sans conteste le numérateur qui intéresse la plupart des couples traités. Signalons cependant que même ce nombre « essentiel » peut porter à confusion s'il n'est pas clairement tenu compte du taux de grossesse multiple. Par exemple, cent naissances vivantes ne signifient pas nécessairement que cent couples ont eu chacun un enfant ; on peut en effet compter parmi ces naissances un nombre important de naissances gémellaires de deux enfants ou plus. Par conséquent, certains auteurs considèrent que la proportion d'accouchements par rapport aux tentatives refléterait plus exactement le taux de succès, en permettant d'établir quelles sont les chances d'atteindre le but visé, c'est-à-dire avoir (au moins) un enfant.

6. La détermination du dénominateur

Pour pouvoir donner un consentement éclairé à l'application d'un traitement de fécondation in vitro, le couple doit être mis au courant des variations et des limites dans les méthodes de calcul[70]. Par exemple, une clinique de fécondation in vitro peut affirmer avoir obtenu un taux de grossesse de 20 pour 100[71]. Or, comme nous l'avons expliqué

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67. H. PAGE, *loc. cit.*, note 66, 334.

68. *Ibid.*

69. *Les crimes contre le fœtus*, *op. cit.*, note 7, p. 45, n. 92.

70. Fiona J. STANLEY, « In-Vitro Fertilization — A Gift for the Infertile or a Cycle of Despair? » (1988), 148 *Med. J. Australia* 425.

71. Voir Kate DUNN, « Today — Cloned Cows. Tomorrow — You? », *The [Montreal] Gazette* (8 juillet 1989), A-1, A-4.

plus haut, le couple devrait d'abord être informé du dénominateur utilisé. S'agit-il du cycle de traitement hormonal ? du prélèvement d'ovocytes ? du transfert d'embryon ? Ensuite, le couple devrait savoir qu'un taux de grossesse de 20 pour 100 par transfert d'embryon n'est pas nécessairement révélateur de toutes les réalités statistiques et psychologiques du processus.

Prenons l'hypothèse où 200 couples s'adresseraient à une clinique de fécondation in vitro qui revendique un taux de réussite de 20 pour 100 par transfert d'embryon. On pourrait en conclure que 40 patientes deviendront enceintes. En fait, il y en aura probablement beaucoup moins parce que plusieurs couples n'atteindront pas l'étape du transfert d'embryon. Environ 40 des 200 couples seront éliminés du programme à la première étape du processus, le cycle de traitement, parce que le taux d'échec des cycles de traitement hormonal dans la fécondation in vitro se situe habituellement à 20 pour 100[72]. Des 160 couples qui restent, 24 autres (15 pour 100) abandonneront probablement avant l'étape du transfert à cause des difficultés rencontrées aux étapes du prélèvement des ovocytes et de la fécondation[73].

Il ne reste donc qu'environ 136 couples qui atteindront l'étape du transfert d'embryon. Si l'on applique le taux de 20 pour 100 par transfert d'embryon avancé par la clinique, environ 27 des 200 femmes tomberont enceintes, et non 40 comme on aurait pu s'y attendre. En termes statistiques, cela signifie un taux de grossesse par cycle de traitement (si l'on prend ce dénominateur) de 13 pour 100 seulement. Force est de constater qu'un « taux de succès de 20 pour 100 », pris isolément, est très équivoque. Il faut connaître le numérateur et le dénominateur, qui doivent être les mêmes pour que l'on puisse comparer les cliniques entre elles. L'utilisation de méthodes uniformes pour rendre compte des taux de succès aiderait les couples à faire des choix vraiment éclairés.

7. Les résultats internationaux

Le tableau I (*infra*, p. 41) indique les plus récentes statistiques des registres nationaux de l'Australie[74] (13 centres), des États-Unis[75] (96 centres) et du Royaume-Uni[76]

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72. Voir, *supra*, note 53 et le texte qui l'accompagne.

73. Entre 10 et 20 pour 100 des patientes soumises à la ponction d'ovocytes n'atteignent pas l'étape du transfert d'embryon. H.W. Jones, Jr. et P.A.W. Rogers, « Results from In Vitro Fertilization », dans C. Wood et A. Trounson (dir.), *op. cit.*, note 52, p. 51, à la page 57.

74. Australian In-Vitro Fertilization Collaborative Group, « In-Vitro Fertilization Pregnancies in Australia and New Zealand, 1979-1985 » (1988), 148 *Med. J. Australia* 429 (ci-après *Australia IVF*). Voir aussi F.J. Stanley, *loc. cit.*, note 70, 425.

75. Medical Research International and the Society of Assisted Reproductive Technology, The American Fertility Society, « In Vitro Fertilization/Embryo Transfer in the United States: 1987 Results from the National IVF/ET Registry » (1989), 51:1 *Fertil. Steril.* 13 (ci-après *U.S. IVF/ET 1989*).

76. *The Fifth Report of the Interim Licensing Authority for Human In Vitro Fertilization and Embryology 1990*, Londres, ILA, 1990, pp. 35-37 (ci-après ILA).

(42 centres). En raison des différentes méthodes de calcul utilisées, il est difficile d'établir un critère commun de « succès ». Cependant, l'évaluation brute du taux d'accouchement (grossesses cliniques moins avortements spontanés et grossesses extra-utérines) par cycle de traitement hormonal n'est pas sans intérêt. Les données actuelles indiquent des taux de succès situés entre 6 et 9 pour 100. Cela constitue toutefois une surestimation du nombre de couples pouvant espérer élever un enfant, parce qu'on ne tient pas compte des enfants morts-nés ou morts peu après la naissance.

De plus, les méthodes d'évaluation varient grandement d'une clinique à l'autre. Par exemple, au Royaume-Uni, l'Interim Licensing Authority (autrefois appelée Voluntary Licensing Authority) classe les données selon la taille du centre : petit, moyen ou grand. Le taux moyen de grossesse clinique est de 14,3 pour 100 dans les 6 grands centres, et de 9,2 pour 100 dans 10 petits centres[77]. En France, il existe aussi une disparité entre les cliniques. En avril 1987, les rapports faisaient état de 17 000 cas de prélèvement d'ovocytes, ayant donné lieu à 1 340 accouchements (7,8 pour 100). Même si le taux de grossesse par transfert d'embryon était généralement de 14 pour 100, certaines cliniques ont revendiqué des taux allant jusqu'à 35 pour 100[78]. Les taux de succès sont plus élevés dans les rapports publiés individuellement que dans ceux qui portent sur des données compilées[79].

8. Les résultats canadiens

Il existe des programmes de fécondation in vitro et de transfert d'embryon au Canada (FIVETE) depuis 1982 ; actuellement, 13 programmes sont actifs. Un rapport récent sur les données provenant de 11 centres canadiens entre 1982 et 1988 fait état de la naissance de 460 enfants vivants sur 5 921 cycles de traitement entrepris pour 3 277 couples. Cela signifie un taux de naissance vivante de 7,9 pour 100 par cycle de traitement et de 14,3 pour 100 par couple traité[80]. Le taux de grossesse multiple n'ayant pas été rapporté, il est impossible de calculer le taux exact d'accouchement. Cependant, sur la base de proportions semblables à celles dont font état d'autres rapports, on peut supposer que la proportion d'enfants nés vivants et viables est inférieure d'environ 20 pour 100 au taux de succès revendiqué.

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77. *Id.*, p. 20.

78. Table ronde à la Conférence de l'ESHRE (European Society of Human Reproduction and Embryology), octobre 1987, par Michelle PLACIOT, J.P. RENARD, Nicole QUESTIAUX et J. TESTART, conférenciers, sous la présidence de R.G. EDWARDS, « Discussion on Ethical and Judicial Aspects of Embryo Research » (1989), 4:2 *Human Reprod.* 206.

79. René FRYDMAN et autres, « An Obstetric Assessment of the First 100 Births from the In Vitro Fertilization Program at Clamart, France » (1986), 154:3 *Am. J. Obstet. Gynecol.* 550 ; Geoffrey SHER et autres, « In Vitro Fertilization and Embryo Transfer: Two-Year Experience » (1986), 67:3 *Obstet. Gynecol.* 309.

80. Voir Stanley E. BROWN, « In Vitro Fertilisation — The Canadian Experience » (1989), 11:3 *Journal SOGC* 27, 28, 31.

Les rapports provenant de cliniques canadiennes individuelles sont rares[81]. Un rapport récent publié par l'University Hospital de London et l'Université de Western Ontario[82] résume les taux de grossesse obtenus à ce centre du 1er février 1984 au 31 décembre 1987, et précise le résultat de ces grossesses. Le rapport fait état d'un taux de grossesse clinique de 12,3 pour 100 par cycle de traitement, et la proportion de couples ayant ramené à la maison au moins un enfant en bonne santé par cycle de traitement est de 6,4 pour 100[83]. Selon les auteurs, ces chiffres représentent une sous-estimation des taux de succès actuels, étant donné les récents progrès de la technologie.

En 1987, l'hôpital Toronto East General a mis sur pied un registre national volontaire confidentiel des grossesses obtenues par fécondation in vitro ou implantation tubaire de gamètes[84]. Ce registre est toutefois incomplet puisque plusieurs centres n'ont pas transmis leurs résultats[85]. Plus récemment, l'Association des médecins de l'Ontario a proposé des lignes directrices (les premières au Canada) pour assurer la qualité des services de fécondation in vitro. Elle y recommande entre autres la création d'un registre provincial qui serait tenu par le ministère de la Santé. Le registre comprendrait des détails sur la filiation, les taux de succès ou d'échec et le résultat des grossesses. Elle recommande aussi que le registre soit confidentiel mais mis à la disposition des médecins aux fins de contrôle[86].

9. Les effets de la fécondation in vitro

Si elle a pour but ultime la naissance d'un enfant, la fécondation in vitro peut aussi avoir d'autres effets : avortement spontané[87], mortalité et morbidité périnatales[88],

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81. Voir *IVF-ET Canada*, *loc. cit.*, note 51, 15. Parmi les quelques rapports existants, mentionnons Patrick J. Taylor et autres, « Initial Experience with In Vitro and Embryo Transfer at the University of Calgary/Foothills Hospital » (1985), 2:2 *J. In Vitro Fert. Embryo Transfer* 112, et Jacques-E. Rioux et autres, « Center for In Vitro Fertilization, Québec, Canada » (1984), 1:1 *J. In Vitro Fert. Embryo Transfer* 89.

82. A.A. Yuzpe et autres, *loc. cit.*, note 66, 167.

83. *Id.*, 169-170. Le taux de 6,4 pour 100 mentionné ici a été établi d'après les taux d'accouchement et de mortinatalité.

84. Voir Note, « Canadian IVF Registry » (1987), 9:3 *SOGC Bulletin* 19.

85. Conversation privée avec J. Tolentino et P. Phillips dans le cadre du programme LIFE à Toronto.

86. Association des médecins de l'Ontario, « OMA Guidelines for In Vitro Fertilization Programs in Ontario » (1990), 57:12 *Ontario Med. Rev.* 28.

87. Selon le rapport, le taux d'avortement spontané est d'environ 25 pour 100, alors qu'il est de 15 pour 100 dans la population en général. Voir le tableau I, *infra*, p. 41.

88. La mortalité périnatale s'entend du nombre de morts foetales (mortinaissances) et néonatales (morts du nouveau-né), à compter du stade de la viabilité jusqu'au vingt-huitième jour après la naissance. Judith S. Mausner et Shira Kramer, *Epidemiology — An Introductory Text*, 2e éd., Philadelphie, W.B. Saunders, 1985, pp. 92-93, 104-106. La morbidité périnatale s'entend des maladies ou malformations chez les nouveau-nés vivants au cours de cette même période. Voir le texte de la note 94, *infra*.

grossesse multipare[89] ou ectopique[90], césarienne[91]. Tous ces phénomènes se manifestent dans des proportions beaucoup plus élevées chez les femmes ayant subi un traitement de fécondation in vitro que dans la population en général.

a) La grossesse multiple et les risques périnatals

Parmi les femmes qui ont subi avec succès une fécondation in vitro ou une implantation tubaire de gamètes, une sur quatre accouche de deux enfants ou plus[92]. Ce taux est beaucoup plus élevé que dans la population en général, où il est évalué à une naissance sur 80 à 95, encore qu'il soit difficile à établir avec précision[93].

Selon un rapport australien récent, les grossesses obtenues par fécondation in vitro ou implantation tubaire de gamètes doivent être considérées comme présentant des risques élevés, en raison du taux de mortalité périnatale trois fois supérieur à celui de la population en général et du pourcentage élevé de bébés hypotrophiques (faible poids à la naissance). Plusieurs facteurs contribuent à cet état de choses, comme l'âge de la mère et le traitement de l'infertilité lui-même. Cela dit, 50 pour 100 des naissances avant terme et 70 pour 100

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89. J. COHEN, M.J. MAYAUX et M.L. GUIHARD-MOSCATO, « Pregnancy Outcomes after *In Vitro* Fertilization: A Collaborative Study of 2342 Pregnancies » (1988), 541 *Ann. N.Y. Acad. Sci.* 1, 5. Voir aussi ILA, *op. cit.*, note 76, p. 19. Le taux de grossesse multipare est d'environ 20 pour 100, comparativement à environ 1 pour 100 dans la population en général (les taux de grossesse multiple dans la population en général varient en fonction de la race, de l'âge et du nombre de grossesses antérieures). Pour une discussion sur l'épidémiologie des naissances multiples, voir Jack A. PRITCHARD, Paul C. MACDONALD et Norman F. GANT, *Williams Obstetrics*, 17e éd., Norwalk (Conn.), Appleton-Century-Crofts, 1985, p. 503.

90. La grossesse ectopique s'entend d'une grossesse qui se développe à l'extérieur de l'utérus, habituellement dans une trompe de Fallope ; dans la plupart des cas, elle est causée par l'obstruction de la trompe, qui empêche l'embryon de pénétrer dans l'utérus. La grossesse tubaire peut devenir une urgence vitale, qui requiert l'ablation chirurgicale de la trompe atteinte. Le taux de grossesse ectopique dans les cas de fécondation in vitro se situe entre 4,5 pour 100 et 7,5 pour 100, comparativement à 1,5 pour 100 dans la population en général. Voir le tableau I, *infra*, p. 41, pour les taux à l'étranger.

91. J. COHEN, M.J. MAYAUX et M.L. GUIHARD-MOSCATO, *loc. cit.*, note 89, 3 ; A.A. YUZPE et autres, *loc. cit.*, note 66, 170. Les taux de césarienne sont de 47 pour 100 en cas de grossesse simple et de 72 pour 100 en cas de grossesse multipare, contre 15 pour 100 et 44 pour 100 respectivement dans la population en général.

92. Une analyse internationale des résultats de la FIV et du GIFT fait état d'un taux de grossesse multiple d'environ 24 pour 100 ; voir les tableaux I et II, *infra*, pp. 41, 42. Ces chiffres indiquent les moyennes nationales. Par contre, il est bien connu que les taux individuels peuvent varier. Par exemple, A.A. YUZPE et autres, *loc. cit.*, note 66, 171, mentionnent un taux de grossesse multipare de 16 pour 100, et R. FRYDMAN et autres, *loc. cit.*, note 79, 552, 554, un taux de 12 pour 100.

93. Le taux exact de grossesse multiple peut être difficile à établir en raison des variations dans les méthodes de calcul sur le plan international. Voir B.J. BOTTING, I. MACDONALD DAVIES et A.J. MACFARLANE, « Recent Trends in the Incidence of Multiple Births and Associated Mortality » (1987), 62 *Arch. Dis. Child.* 941, 942. Le phénomène du « jumeau disparu » (*vanishing twin*) complique encore l'analyse du nombre de fœtus par grossesse ; ce phénomène décrit le taux de réduction spontané des grossesses gémellaires qui entraîne la perte d'au moins l'un des fœtus. Des études échographiques effectuées sur des femmes en début de grossesse ont démontré un taux de réduction spontané des fœtus semblable ou supérieur au taux d'avortement spontané dans les cas de grossesse simple. Par conséquent, si les taux dont font état les cliniques de fécondation in vitro concernent la gémellité détectée en début de grossesse, ils sont supérieurs à ceux enregistrés lors de l'accouchement. Voir la discussion sur ce sujet dans Katharine D. WENSTROM et Stanley A. GALL, « Incidence, Morbidity and Mortality, and Diagnosis of Twin Gestations » (1988), 15:1 *Clinics Perinatol.* 1, 2.

des cas de nouveau-nés à faible poids ont été associés aux grossesses multiples[94]. Des 460 enfants nés vivants au Canada entre 1982 et 1987 à la suite d'une fécondation in vitro, 21 sont morts peu après leur naissance (mort néonatale) ; il s'agissait dans la plupart des cas d'une naissance prématurée, souvent associée à une grossesse multipare[95].

La mortalité périnatale est toujours plus élevée chez les jumeaux que chez les enfants nés d'une grossesse unipare. En Amérique du Nord, le taux de mortalité est de 14 à 16 pour 1000 grossesses simples. Il est de quatre à sept fois plus élevé pour les grossesses multiples[96]. Les grossesses gémellaires, qui constituent seulement 1 pour 100 de toutes les naissances, comptent en effet pour 10 pour 100 de tous les accouchements prématurés et 25 pour 100 des décès avant terme[97]. Parmi les effets de la prématurité, on note les difficultés respiratoires[98], la prédisposition aux hémorragies cérébrales et méningées[99], et l'infection[100].

Outre leur poids généralement plus faible à la naissance en raison de leur prématurité, les jumeaux sont exposés à des risques plus élevés de retard de croissance[101]. À ce retard sont associés des risques de souffrance fœtale pendant le travail, d'anoxie (asphyxie) et éventuellement de mortinatalité[102].

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94. Douglas M. SAUNDERS et Paul LANCASTER, « The Wider Perinatal Significance of the Australian In Vitro Fertilization Data Collection Program » (1989), 6:2 *Am. J. Perinatol.* 252, 252-253. Voir aussi *Australia IVF*, *loc. cit.*, note 74, 433. Sur 1 138 bébés nés vivants, 438 (38,5 pour 100) étaient issus de grossesses multiples. Voir aussi F.J. STANLEY, *loc. cit.*, note 70, 425.

95. S.E. BROWN, *loc. cit.*, note 80, 28, 31.

96. Joel I. POLIN et William L. FRANGIPANE, « Current Concepts in Management of Obstetric Problems for Pediatricians » (1986), 33:3 *Pediatr. Clin. N. Am.* 649, 650. Voir aussi K.D. WENSTROM et S.A. GALL, *loc. cit.*, note 93, 3, et B.J. BOTTING, I. MACDONALD DAVIES et A.J. MACFARLANE, *loc. cit.*, note 93, 945.

97. Voir J.I. POLIN et W.L. FRANGIPANE, *loc. cit.*, note 96, 650. Voir aussi K.D. WENSTROM et S.A. GALL, *loc. cit.*, note 93, 4-5.

98. Le syndrome de détresse respiratoire survient le plus souvent chez les enfants prématurés souffrant d'une carence en surfactant, substance qui contribue à la distension normale des poumons. Ce syndrome est particulièrement répandu (48 pour 100) chez les jumeaux entre la 25e et la 32e semaine de gestation (prématurés de 15 à 8 semaines). Voir K.D. WENSTROM et S.A. GALL, *loc. cit.*, note 93, 5.

99. Chez les jumeaux nés entre la 25e et la 32e semaine de gestation, les risques d'hémorragie dans les ventricules cérébraux sont d'au moins 20 pour 100. K.D. WENSTROM et S.A. GALL, *loc. cit.*, note 93, 5.

100. Il a été établi que le risque pour les enfants pesant moins de 2 500 grammes d'être atteints de la maladie streptococcique de groupe B est cinq fois plus élevé chez les jumeaux que chez les enfants uniques. Voir Kristine MCCULLOCH, « Neonatal Problems in Twins » (1988), 15:1 *Clin. Perinatol.* 141, 151.

101. Les expressions « retard staturo-pondéral intra-utérin » et « hypotrophie » désignent l'état du fœtus ou du nouveau-né qui, comparativement aux poids observés chez les fœtus uniques dans la population en général, est sensiblement plus petit, compte tenu de son âge gestationnel. Par exemple, le bébé qui, né à la 35e semaine de grossesse, a la taille moyenne d'un bébé de 32 semaines sera jugé atteint d'un retard de croissance et plus à risque que le bébé né à une taille conforme à sa période de gestation. Voir J.I. POLIN et W.L. FRANGIPANE, *loc. cit.*, note 96, 657. Voir aussi Richard BRONSTEEN, Gregory GOYERT et Sidney BOTTOMS, « Classification of Twins and Neonatal Morbidity » (1989), 74:1 *Obstet. Gynecol.* 98, 100.

102. J.I. POLIN et W.L. FRANGIPANE, *loc. cit.*, note 96, 657; R. BRONSTEEN, G. GOYERT et S. BOTTOMS, *loc. cit.*, note 101, 100.

Selon une étude collective internationale sur la fécondation in vitro effectuée dans 55 centres, le taux de malformations congénitales en cas de naissances multiples n'est que légèrement supérieur à celui observé chez les enfants uniques (3,6 pour 100 contre 2,5 pour 100)[103]. Par contre, des études sur les conséquences à long terme des naissances gémellaires révèlent un taux plus élevé de difficultés d'apprentissage, de déficiences motrices, de problèmes d'élocution et de retards dans la croissance physique[104]. Quant à la mère, pendant et après la grossesse, elle court des risques accrus d'hypertension artérielle attribuable à la grossesse, d'anémie, de césarienne et d'hémorragie post-partum[105].

Dans environ 15 pour 100 des grossesses multipares liées à la fécondation in vitro, il y a trois bébés ou plus. Et lorsqu'il y a plus de deux fœtus, les risques augmentent sensiblement, à la fois pour la mère et pour les enfants. Par exemple, le taux de mortalité périnatale est environ trois fois plus élevé chez les triplets que chez les jumeaux[106].

b) Les techniques de réduction des grossesses multiples

Louise Brown a été le premier « bébé-éprouvette ». Sa naissance en 1978 faisait suite à la fécondation in vitro d'un seul ovule, prélevé au cours d'un cycle naturel et réimplanté dans l'utérus. Les techniques utilisées pour prévoir la maturation de l'ovule et l'ovulation étaient alors assez primitives et imprécises. Le prélèvement de l'ovule exigeait que l'équipe chirurgicale soit disponible 24 heures sur 24, et le taux de succès du prélèvement restait encore inférieur à 50 pour 100. Les échecs aux étapes de la fécondation et de l'implantation diminuaient encore le taux de succès déjà faible du processus. Les techniques de stimulation ovarienne ont alors été conçues pour augmenter les chances de réussite. Elles ont eu pour effet de provoquer la maturation de plusieurs ovocytes par cycle et d'assurer une meilleure maîtrise du processus d'ovulation, ce qui s'est traduit par des taux de grossesse plus élevés[107]. Cependant, comme nous l'avons vu ci-dessus, la probabilité d'une grossesse multipare, avec les risques qu'elle comporte, a aussi augmenté. Comment alors obtenir tous les avantages que procurent les implantations multiples tout en réduisant les risques d'une grossesse multipare ? En d'autres termes, quel est le nombre optimal d'embryons qui devraient être transférés dans l'utérus à la fois ?

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103. Voir J. COHEN, M.J. MAYAUX et M.L. GUIHARD-MOSCATO, *loc. cit.*, note 89, 3.

104. K.D. WENSTROM et S.A. GALL, *loc. cit.*, note 93, 5 ; J.I. POLIN et W.L. FRANGIPANE, *loc. cit.*, note 96, 650-651.

105. J.A. PRITCHARD, P.C. MACDONALD et N.F. GANT, *op. cit.*, note 89, p. 503.

106. B.J. BOTTING, I. MACDONALD DAVIES et A.J. MACFARLANE, *loc. cit.*, note 93, 946.

107. G. SHER et H.C. CHOTINER, « Controlled Ovarian Hyperstimulation for IVF », dans Christopher M. FREDERICKS, John D. PAULSON et Alan H. DECHERNEY (dir.), *Foundations of In Vitro Fertilization*, Cambridge, Hemisphere, 1987, p. 83.

Cette question prête à controverse sous plusieurs rapports, en particulier quant au taux acceptable de grossesse multiple[108]. Par ailleurs, le lien entre le nombre d'embryons implantés et la proportion des grossesses multipares qui en résultent n'est pas clair, notamment en raison des modes de calcul utilisés dans la littérature. Dans un rapport, toutefois, on a démontré qu'en cas de transfert de 4, 5, 6 et 7 embryons, les chances de donner naissance à au moins un enfant étaient respectivement de 18 pour 100, 17 pour 100, 18 pour 100 et 18 pour 100, et les risques d'une grossesse multiple étaient de 16,7 pour 100, 31,6 pour 100, 50 pour 100 et 50 pour 100[109]. Autrement dit, même si les chances de donner naissance à un enfant ne sont pas meilleures avec plus de quatre embryons, les risques de grossesse multiple sont considérablement accrus. De plus, le même rapport montre que l'implantation de trois embryons entraîne un taux de naissance de 12 pour 100, mais un taux de grossesse multipare de 21 pour 100[110]. Comme le montre le tableau III (*infra*, p. 42), cette tendance non linéaire se retrouve aussi dans d'autres rapports, ce qui prouve que le nombre d'embryons transférés ne constitue pas le seul facteur déterminant des taux de grossesse et de grossesse multiple.

Le succès de la grossesse dépend à la fois de la réceptivité de l'utérus à l'implantation et de la « qualité » des embryons transférés[111]. Ces caractéristiques sont actuellement difficiles à mesurer sur le plan clinique. De plus amples recherches sont essentielles dans ce domaine pour améliorer le taux de succès des techniques de procréation médicalement assistée, tout en diminuant le nombre des embryons qui doivent être implantés[112]. En attendant, la méthode la plus généralement acceptée pour réduire le risque de grossesse multiple consiste à limiter le nombre d'embryons transférés par traitement.

Au cours des dernières années, la limitation du nombre d'embryons transférés a retenu l'attention de nombreux pays. Au Royaume-Uni[113] et en Australie, par exemple, les corporations professionnelles nationales ont mis en vigueur des lignes directrices restreignant à trois ou, dans des cas extrêmes, à quatre le nombre d'embryons pouvant être transférés en même temps[114]. Ces critères n'ont toutefois pas été acceptés par tous les médecins. Une équipe britannique de spécialistes de l'infertilité s'est opposée aux restrictions, revendiquant plutôt une certaine latitude pour décider du nombre d'embryons

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108. Simon FISHEL et John WEBSTER, « IVF and Associated Techniques: Whom Can We Believe? » (1987), II:8553 *Lancet* 273.

109. *U.S. IVF/ET 1989*, *loc. cit.*, note 75, 16.

110. *Ibid.*

111. Anibal A. ACOSTA et autres, « Implantation Potential of Each Pre-Embryo in Multiple Pregnancies Obtained by In Vitro Fertilization Seems to Be Different » (1988), 50:6 *Fertil. Steril.* 906.

112. Jan TESARIK, « Viability Assessment of Preimplantation Concepti: A Challenge for Human Embryo Research » (1989), 52:3 *Fertil. Steril.* 364.

113. Voir ILA, *op. cit.*, note 76, p. 22, et Ian CRAFT, Peter R. BRINSDEN et Eric G. SIMONS, « Voluntary Licensing and IVF/ET » (1987), I:8542 *Lancet* 1148.

114. C.R. AUSTIN, « Voluntary Regulatory Scheme for Clinics Practising IVF and Related Technologies in Australia » (1989), 4:7 *Human Reprod.* 854. Voir aussi ILA, *op. cit.*, note 76.

à implanter à la suite de la fécondation in vitro ou du nombre d'ovules à transférer pour une implantation tubaire de gamètes[115]. Le professeur Craft et ses collègues ont fait valoir que, dans certains cas, diminuer le nombre d'ovules limite injustement les chances de grossesse. Selon eux, le jugement clinique devrait prévaloir sur le strict respect des critères établis, comme c'est généralement le cas en médecine. Par exemple, les chances de grossesse, unipare ou multipare, diminuent avec l'âge[116], ce qui justifie parfois l'implantation d'un plus grand nombre d'embryons pour provoquer une grossesse. D'autre part, une grossesse antérieure augmente les possibilités de grossesse multiple. Le risque individuel de grossesse multipare varie donc en fonction de divers facteurs. De plus, on a remarqué que les taux de grossesse multiple varient beaucoup selon les cliniques, même lorsque le nombre d'embryons transférés par cycle est le même[117].

Au Canada, certaines cliniques ont établi leur propre politique quant au nombre d'embryons pouvant être transférés. La plupart admettent que l'implantation d'un maximum de trois ou quatre embryons réduit les risques de grossesse multiple, mais elles ne sont pas toutes équipées pour congeler les embryons surnuméraires. Les installations de cryoconservation permettent l'entreposage de ces embryons en vue d'un usage futur par le couple. S'ils ne sont pas utilisés plus tard, ils peuvent être donnés, utilisés pour la recherche ou détruits, selon les désirs du couple[118].

Si aucune installation de congélation n'est disponible, le transfert de plus de quatre embryons dans l'utérus peut avoir pour conséquence une grossesse multipare d'un ordre supérieur. Lorsque plus de trois embryons s'implantent, la possibilité d'une réduction foetale sélective peut être offerte au couple[119]. Quoique le procédé ait soulevé un débat moral

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115. I. Craft, P.R. Brinsden et E.G. Simons, *loc. cit.*, note 113 ; Ian Craft et autres, « Licensing Work on IVF and Related Procedures » (1987), I:8546 *Lancet* 1373 ; Ian Craft, « How Many Oocytes/Embryos Should Be Transferred? » (1987), II:8550 *Lancet* 109 ; Ian Craft et autres, « Multiple Pregnancy, Selective Reduction, and Flexible Treatment » (1988), II:8619 *Lancet* 1087.

116. I. Craft et autres, « Analysis of 1071 GIFT Procedures — The Case for a Flexible Approach to Treatment » (1988), I:8594 *Lancet* 1094. D'autres rapports corroborent l'affirmation du professeur Craft suivant laquelle les grossesses multiples sont moins fréquentes chez les femmes plus âgées. Par exemple, Corson et ses collègues déclarent que les risques de grossesse multipare diminuent de 9 pour 100 par année après 30 ans ; voir Stephen L. Corson et autres, « Outcome in 242 In Vitro Fertilization-Embryo Replacement or Gamete Intrafallopian Transfer-Induced Pregancies » (1989), 51:4 *Fertil. Steril.* 644, 645. Pour une discussion de l'effet de l'âge sur le succès de la fécondation in vitro, voir aussi Santiago L. Padilla et Jairo E. Garcia, « Effect of Maternal Age and Number of In Vitro Fertilization Procedures on Pregnancy Outcome » (1989), 52:2 *Fertil. Steril.* 270.

117. Un taux de grossesse multiple de 12 pour 100 a été observé dans un programme de fécondation in vitro en France, comparativement à un taux de 25,4 pour 100 en Belgique, alors que les deux centres adhèrent à une politique interdisant le transfert de plus de 3 embryons à la fois. Voir R. Frydman et autres, *loc. cit.*, note 79, 553. Voir aussi P. Barlow et autres, « Early Pregnancy Loss and Obstetrical Risk After In-Vitro Fertilization and Embryo Replacement » (1988), 3:5 *Human Reprod.* 671, 675.

118. Au sujet de la congélation des embryons, voir *infra*, pp. 34-35 ; voir aussi A. Trounson, « Embryo Cryopreservation », dans C. Wood et A. Trounson (dir.), *op. cit.*, note 52, p. 127, aux pages 138-139.

119. Le « foeticide » sélectif est désigné dans la littérature sous les noms de réduction sélective des foetus, d'embryocide sélectif, d'avortement sélectif ou de naissance sélective. Le procédé consiste à éliminer un ou plusieurs fœtus pendant la grossesse.

à la fois semblable et différent de celui de l'avortement[120], on s'entend généralement pour admettre que le risque est plus élevé, tant pour les fœtus que pour la mère, si la grossesse se poursuit telle quelle que si le nombre de fœtus est réduit.

Les risques associés aux techniques de réduction comprennent l'avortement spontané, l'échec de la réduction, l'infection et, plus rarement, un trouble de la coagulation qui peut mettre en danger les fœtus qui restent et la mère elle-même[121]. Sur le plan émotif, on ignore encore les effets de la réduction fœtale sélective pour la mère, le père et les autres enfants ; par conséquent, il faudrait peut-être songer à leur fournir une assistance socio-psychologique avant ou après l'intervention.

Il est clair que de plus amples recherches sur le problème des grossesses multiples sont nécessaires. Grâce à une technique expérimentale prometteuse, il paraît cependant possible de réduire le taux de grossesse multiple au même niveau que celui observé dans la population en général. Lors d'un essai restreint effectué sur un cycle non stimulé, on a obtenu un taux de grossesse clinique de 22,5 pour 100, la grossesse se poursuivant dans une proportion de 17,5 pour 100 par cycle[122], ce qui est aussi bien et même mieux que les résultats obtenus au moyen des techniques de stimulation ovarienne. Ce procédé élimine en outre les risques liés à l'utilisation des médicaments provoquant la stimulation ovarienne[123]. De plus, il semble que le cycle naturel produise un ovule de meilleure qualité et une réceptivité utérine optimale. Moins brutal, le procédé permet des tentatives plus fréquentes, donc de meilleures chances de provoquer une grossesse. Et parmi les avantages non médicaux, mentionnons le coût moindre[124] et l'élimination des questions d'ordre moral et juridique que soulèvent les embryons surnuméraires. Il est cependant trop tôt pour affirmer que ces résultats peuvent être réalisés dans d'autres cliniques. Par ailleurs, le principal inconvénient de cette technique est l'échec du prélèvement dans 10 à 30 pour 100 des cas, et l'annulation de cycles en raison de l'imprécision du contrôle hormonal[125].

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120. « Selective Fetal Reduction » (1988), II:8614 *Lancet* 773.

121. Ronald J. Wapner et autres, « Selective Reduction of Multifetal Pregnancies » (1990), 335:8681 *Lancet* 90, 91. Pour une étude complète de l'historique du procédé et des risques qu'il comporte, voir Fay O. Redwine et Patricia M. Hays, « Selective Birth » (1986), 10:1 *Seminars Perinat.* 73, 75-78.

122. Dans le cycle non stimulé, aucun médicament de fertilité n'est utilisé. L'ovule arrive naturellement à maturité ; il est alors prélevé, fécondé et implanté, ce qui élimine le problème des grossesses multiples et des embryons surnuméraires. Hervé Foulot et autres, « In Vitro Fertilization without Ovarian Stimulation: A Simplified Protocol Applied in 80 Cycles » (1989), 52:4 *Fertil. Steril.* 617, 617-621. Voir aussi Jairo Garcia, « Return to the Natural Cycle for In Vitro Fertilization (Alleluia!, Alleluia!) » (1989), 6:2 *J. In Vitro Fert. Embryo Transfer* 67, 67-68.

123. Pour une étude des risques associés aux médicaments provoquant la stimulation ovarienne, voir J.L. Kennedy et E.Y. Adashi, *loc. cit.*, note 34 ; voir aussi *supra*, pp. 11, 14-15. Voir enfin D. Navot et autres, *loc. cit.*, note 56.

124. On estime que le coût de l'intervention est réduit de 6 000 $ U.S. à 1 000 $ U.S. pour chaque tentative. Voir J. Garcia, *loc. cit.*, note 122, 68.

125. Communicative privée avec le Dr E. Hughes de l'Université McMaster, Hamilton (Ontario).

c) Les malformations congénitales

Il est difficile de savoir si le taux de malformations congénitales est plus élevé chez les nouveau-nés conçus par fécondation in vitro que chez ceux conçus naturellement. Parmi les facteurs extrinsèques qui pourraient provoquer une augmentation à cet égard, mentionnons l'âge généralement plus élevé de la mère (d'où le risque plus grand d'aberrations chromosomiques et autres malformations congénitales), le nombre accru de grossesses multipares, les causes sous-jacentes à l'infertilité et les diverses interventions cliniques, notamment la manipulation des gamètes et des embryons. Sur 1 694 naissances faisant suite à une fécondation in vitro en Australie et en Nouvelle-Zélande entre 1979 et 1986, on a relevé un taux de malformations congénitales, y compris les aberrations chromosomiques, de 2,2 pour 100 (comparativement à un taux de 1,5 pour 100 dans le reste de la population)[126].

On a laissé entendre que le taux plus élevé d'anomalies pouvait être attribuable au manque d'objectivité des observateurs, les anomalies ayant été recherchées avec plus d'attention chez les nouveau-nés conçus par fécondation in vitro que chez ceux conçus naturellement[127]. Il serait donc opportun d'effectuer des études systématiques plus étendues pour vérifier si le risque de malformations est effectivement plus élevé chez les enfants nés d'une fécondation in vitro.

Au moment où le présent document a été rédigé, les taux de malformations congénitales chez les enfants conçus par fécondation in vitro au Canada n'étaient pas disponibles[128]. Il a été recommandé que ce renseignement soit inclus dans les registres sur les résultats des grossesses médicalement assistées[129].

d) Les effets psychologiques

La simple description des techniques de fécondation in vitro et de leurs résultats ne reflète pas leurs effets psychologiques sur les couples. L'auteur d'une enquête effectuée

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126. Paul A.L. LANCASTER, « Congenital Malformations after In-Vitro Fertilisation » (1987), II:8572 *Lancet* 1392 (lettre). L'auteur mentionne une augmentation significative de deux types de malformations congénitales, comparativement à la population en général, soit le spina-bifida (fermeture incomplète de la colonne vertébrale) et une anomalie cardiaque grave (transposition des gros vaisseaux).

127. Quatre-vingt-trois nouveau-nés conçus par fécondation in vitro et quatre-vingt-treize conçus naturellement ont été observés par la méthode à simple insu. Aucune augmentation statistiquement importante des anomalies n'a été observée. Même s'ils se font rassurants quant aux augmentations importantes des anomalies, les auteurs préviennent que la taille de l'échantillon n'était pas assez significative pour détecter une augmentation légère ou moyenne des anomalies. Voir Norma C. MORIN et autres, « Congenital Malformations and Psychosocial Development in Children Conceived by In Vitro Fertilization » (1989), 115:2 *J. Pediatr.* 222, 226.

128. S.E. BROWN, *loc. cit.*, note 80, 31.

129. Voir ILA, *op. cit.*, note 76, p. 34. Voir aussi ASSOCIATION DES MÉDECINS DE L'ONTARIO, *loc. cit.*, note 86.

auprès de vingt femmes ayant eu recours à la fécondation in vitro a découvert que, pour la plupart, l'intervention a été extrêmement difficile, à la fois sur les plans physique et émotif. Elles ont déclaré avoir éprouvé surtout une peur profonde de l'échec à chacune des diverses étapes menant au transfert d'embryon, et se sont dites tiraillées par un « conflit psychologique intense » entre l'espoir et le réalisme quant à leurs chances de devenir enceintes[130].

Les angoisses causées par l'infertilité et la fécondation in vitro sont telles qu'en Australie, la loi exige qu'une assistance socio-psychologique soit fournie aussi bien avant qu'après l'intervention[131]. De fait, les lignes directrices de l'Association des médecins de l'Ontario sur la fécondation in vitro disposent qu'une telle assistance devrait être mise à la disposition de tous les couples[132].

B. L'implantation tubaire de gamètes (GIFT)

L'implantation tubaire de gamètes consiste à transférer les spermatozoïdes et les ovules non fécondés directement dans les trompes de Fallope[133]. Elle est généralement précédée d'une stimulation ovarienne parce que le nombre accru d'ovules augmente les chances de grossesse. À l'aide d'un laparoscope, les ovocytes mûrs sont aspirés des follicules, mélangés au sperme, puis placés dans une seringue. Le mélange est ensuite réimplanté profondément dans les trompes, ce qui permet une fécondation naturelle. L'intervention prend au total de trente-cinq à soixante minutes environ[134].

Cette intervention est contre-indiquée chez les femmes souffrant de dysfonction tubaire, en raison du risque de grossesse ectopique[135]. Par conséquent, alors que les indications pour l'implantation tubaire de gamètes coïncident dans une certaine mesure avec celles de la fécondation in vitro (c'est-à-dire l'infertilité inexpliquée, l'endométriose, la stérilité masculine et les causes cervicales ou immunologiques), elles excluent le plus large groupe de candidates, celles atteintes de stérilité tubaire[136].

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130. Voir Linda S. Williams, « No Relief until the End: The Physical and Emotional Costs of In Vitro Fertilization », dans Christine Overall (dir.), *The Future of Human Reproduction*, Toronto, Women's Press, 1989, p. 120.

131. Paul Bravender-Coyle, « In Vitro-Fertilization and the Law in Australia » (1986), 6:3 *Health L. Can.* 61, 64.

132. Association des médecins de l'Ontario, *loc. cit.*, note 86, 28.

133. M.M. Seibel, *loc. cit.*, note 49, 832.

134. R.H. Asch et autres, « Gamete Intrafallopian Transfer: International Cooperative Study of the First 800 Cases » (1988), 541 *Ann. N.Y. Acad. Sci.* 722, 724.

135. Voir David L. Olive et autres, « Gamete Intrafallopian Transfer (GIFT) Complicated by Bilateral Ectopic Pregnancy » (1988), 49:4 *Fertil. Steril.* 719, 720.

136. Voir P.A.L. Lancaster, « Outcome of Pregnancy », dans C. Wood et A. Trounson (dir.), *op. cit.*, note 52, p. 81, à la page 82 ; R.H. Asch et autres, *loc. cit.*, note 134, 723 ; et A.A. Yuzpe et autres, *loc. cit.*, note 66, 168.

Le principal avantage de l'implantation tubaire de gamètes est qu'elle exige un minimum d'installations de laboratoire. Son principal inconvénient réside dans la nécessité d'une anesthésie générale, en raison de la laparoscopie. La technique est donc plus agressive que la fécondation in vitro pratiquée dans la plupart des centres. Toutefois, ce problème est peut-être temporaire : selon certains rapports, en effet, il serait possible de prélever l'ovule et d'effectuer le transfert au moyen de méthodes échographiques vaginales[137]. La mise au point de cette technique devrait éliminer progressivement le recours à la laparoscopie.

1. Les taux de succès

Dans une étude collective internationale effectuée sur les 800 premiers cas d'implantation tubaire de gamètes, sur la base d'un protocole commun pour le prélèvement d'ovocytes, le taux de grossesse clinique a été établi à 34,4 pour 100, et le taux d'accouchement à 25 pour 100 par cycle de traitement[138]. Des rapports nationaux en provenance des États-Unis, du Royaume-Uni et de l'Australie indiquent des taux de grossesse clinique se situant entre 21 et 25 pour 100[139] par cycle de transfert, ce qui est supérieur au taux de 17 à 21 pour 100 observé dans les cas de fécondation in vitro au regard d'un critère de grossesse semblable[140]. Le taux de grossesse viable n'a pu être calculé parce que les données anglaises ne précisaient pas la proportion d'avortement spontané. Les rapports australiens et américains ont cependant révélé un taux d'accouchement par prélèvement d'ovocytes de 18 pour 100. La fréquence des grossesses multiples est légèrement supérieure à celle établie pour la fécondation in vitro ; elle varie entre 20 et 28 pour 100[141].

Encore une fois, les rapports fondés sur des données nationales compilées indiquent des taux de succès moyens inférieurs à ceux provenant de centres individuels[142].

2. Les complications

L'étude collective effectuée sur les 800 cas n'a révélé aucune complication majeure imputable à l'intervention ou à l'anesthésie, et le rapport ne fait mention d'aucun cas de

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137. R.P.S. Jansen, « Gamete Intra-fallopian Transfer », dans C. Wood et A. Trounson (dir.), *op. cit.*, note 52, p. 63, à la page 72.

138. R.H. Asch et autres, *loc. cit.*, note 134, 722-725.

139. Voir tableau II, *infra*, p. 42.

140. Voir tableau I, *infra*, p. 41 ; le taux de grossesse clinique est calculé sur la base du nombre de transferts d'embryon.

141. Pour des détails, voir le tableau II, *infra*, p. 42.

142. C. Borrero et autres, « The GIFT Experience: An Evaluation of the Outcome of 115 Cases » (1988), 3:2 *Human Reprod.* 227. Voir aussi Christopher J. Haines et Robert T. O'Shea, « Unilateral Gamete Intrafallopian Transfer: The Preferred Method? » (1989), 51:3 *Fertil. Steril.* 518, 519.

salpingite aiguë[143], mais les risques habituels inhérents à l'anesthésie et à la laparoscopie sont toujours présents. Bien que le taux de grossesse ectopique ne semble pas supérieur à celui que l'on a pu observer dans les cas de fécondation in vitro[144], des rapports indiquent un taux aussi élevé que 30 pour 100 chez les femmes atteintes de dysfonction tubaire non décelable[145].

C. Les autres techniques

On a mis au point plusieurs variantes de la fécondation in vitro et de l'implantation tubaire de gamètes, dont le transfert péritonéal d'ovocytes et de spermatozoïdes (POST), le transfert de pronucleus (PROST) et le transfert tubaire d'embryon (TEST).

Le transfert péritonéal d'ovocytes et de spermatozoïdes suppose l'implantation, au moyen d'une aiguille, des ovules et des spermatozoïdes à travers la paroi vaginale postérieure ; le liquide normal de la cavité abdominale sert alors de véhicule pour le transfert dans la trompe de Fallope. Dans le transfert de pronucleus, les ovules sont fécondés in vitro et transférés directement dans les trompes. Le transfert tubaire d'embryon, quant à lui, consiste à implanter dans les trompes les embryons (congelés au stade de quatre à huit cellules[146]) au début de leur développement. Aucune de ces techniques n'a été utilisée sur une grande échelle, et les rapports émanant des centres canadiens ne les mentionnent pas.

La culture intravaginale (IVC), dont un centre canadien a fait état, constitue aussi une variante de la fécondation in vitro et de l'implantation tubaire de gamètes[147]. Les ovules et les spermatozoïdes sont déposés dans un tube capillaire et insérés dans le vagin de la femme, où on les laisse incuber pendant environ deux jours. Le tube est maintenu en place par un diaphragme vaginal. Les embryons sont ensuite transférés dans l'utérus. Cette technique a l'avantage de simplifier les manipulations en laboratoire et de diminuer le coût de l'intervention. Une étude préliminaire avec allocation aléatoire n'a démontré aucune différence dans les taux de grossesse entre la fécondation in vitro et la culture intravaginale.

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143. R.H. Asch et autres, *loc. cit.*, note 134, 724.

144. Les rapports indiquent un taux de grossesse ectopique situé entre 3 pour 100 et 6 pour 100, c'est-à-dire semblable au taux relevé pour la fécondation in vitro, mais supérieur à celui de 1,5 pour 100 observé dans la population en général. Voir R.H. Asch et autres, *loc. cit.*, note 134, 724 ; C. Borrero et autres, *loc. cit.*, note 142, 228. Voir aussi *supra*, note 90.

145. R.P.S. Jansen, *loc. cit.*, note 137, 73.

146. Pour une description des techniques du PROST et du TEST, voir John L. Yovich, Jeanne M. Yovich et W. Rohini Edirisinghe, « The Relative Chance of Pregnancy Following Tubal or Uterine Transfer Procedures » (1988), 49:5 *Fertil. Steril.* 858, 859-860. Voir aussi Vinay Sharma, Bridgett Mason et Stuart Campbell, « Ultrasound-Guided Peritoneal Oocyte and Sperm Transfer » (1988), 541 *Ann. N.Y. Acad. Sci.* 767 (analyse de la technique du POST).

147. Claude Ranoux et autres, « A New In Vitro Fertilization Technique: Intravaginal Culture » (1988), 49:4 *Fertil. Steril.* 654, 656.

D. L'insémination artificielle

Selon la littérature, les premiers cas d'insémination artificielle réussie remontent au XVIII[e] siècle[148] ; ce procédé représente la plus simple et la plus ancienne des techniques de procréation. L'on évalue actuellement à entre 10 000 et 20 000 le nombre de nouveau-nés conçus chaque année en Amérique du Nord par insémination artificielle[149]. Cette technique constitue une solution simple, non effractive et relativement peu coûteuse à l'infertilité masculine, bien que certains nouveaux procédés d'insémination artificielle tendent à devenir presque aussi agressifs que les autres techniques de procréation[150].

Pour réaliser l'insémination artificielle ou thérapeutique, on peut avoir recours au sperme du mari ou partenaire ; l'insémination est alors dite homologue[151]. On peut aussi utiliser le sperme d'un donneur ; on parle alors d'insémination hétérologue[152]. On aura recours à l'insémination hétérologue une fois que l'infertilité masculine a été établie et que les traitements médicaux ont échoué[153]. Son usage est aussi indiqué dans certains cas de maladie génétique chez l'un des partenaires[154].

L'insémination artificielle homologue est indiquée chez moins de 20 pour 100 des couples touchés par l'infertilité masculine. Pour certains, par exemple, il suffit que le sperme ne soit pas mis en contact avec les sécrétions vaginales pour que la fécondation soit possible. Cette technique est aussi utilisée dans des cas d'anomalies anatomiques de l'homme, tel l'hypospadias, où le méat urétral est situé ailleurs qu'au bout du pénis, ou d'anomalies maternelles, par exemple une déviation utérine[155].

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148. Pour une étude de l'historique de l'insémination artificielle, voir Derek J. JONES, « Artificial Procreation, Societal Reconceptions: Legal Insight from France » (1988), 36 *Am. J. Comp. L.* 525, 530-533.

149. Barbara Eck MENNING, « The Psychology of Infertility », dans James AIMAN (dir.), *Infertility: Diagnosis and Management*, New York, Springer-Verlag, 1986, p. 17, à la page 23. Par ailleurs, selon une étude canadienne publiée en 1981, environ 500 inséminations étaient pratiquées chaque mois dans des cliniques canadiennes et plus de 1 500 bébés étaient nés à ce moment-là par suite d'une insémination artificielle avec sperme de donneur. Voir *Rapport du Comité consultatif sur le stockage et l'utilisation du sperme humain*, Ottawa, Santé et Bien-être social Canada, 1981, pp. x-xi (ci-après *Rapport sur le sperme humain de 1981*).

150. L'insémination intrapéritonéale directe (ou DIPI) consiste à déposer le sperme, à l'aide d'une aiguille et d'un tube, à travers la partie postérieure du vagin, dans un espace contenant un fluide et situé près des ovaires et des trompes, ce qui permet d'éviter l'utérus. Voir P. DELLENBACH et autres, « Direct Intraperitoneal Insemination: New Treatment for Cervical and Unexplained Infertility » (1988), 541 *Ann. N.Y. Acad. Sci.* 761. Voir aussi R.P.S. JANSEN, *loc. cit.*, note 137, 72.

151. Heather BRYANT, *L'infertilité à l'heure de la procréatique ... et la prévention ?*, Ottawa, Conseil consultatif sur la situation de la femme, 1990, p. 4.

152. *Ibid.*

153. N.J. ALEXANDER et S. ACKERMAN, *loc. cit.*, note 39, 907-908.

154. Entre 1 et 10 pour 100 des inséminations artificielles sont effectuées pour prévenir la transmission de maladies génétiques héréditaires. Voir James AIMAN, « Artificial Insemination », dans J. AIMAN (dir.), *op. cit.*, note 149, p. 277, et Pierre JALBERT et autres, « Genetic Aspects of Artificial Insemination with Donor Semen: The French CECOS Federation Guidelines » (1989), 33 *Am. J. Med. Genet.* 269, 272.

155. D.W. KELLER, R.C. STRICKLER et J.C. WARREN, *op. cit.*, note 29, pp. 203-204.

1. La technique

Il est généralement reconnu que le sperme de donneur devrait être congelé avant l'usage, parce que cela permet : d'effectuer des épreuves de dépistage pour réduire les risques de transmission de maladies infectieuses comme le sida[156] ; la disponibilité accrue de spécimens provenant du même donneur pour des inséminations répétées ; de meilleures chances d'assortir les caractéristiques de la receveuse à celles du donneur[157].

Le sperme peut aussi être congelé si le déposant désire le préserver en vue d'un usage futur. Par exemple, la radiothérapie utilisée pour traiter certains cancers peut avoir comme effet secondaire d'inhiber définitivement la spermatogénèse[158]. La mise en banque du sperme avant la radiation peut donc être souhaitable.

Le procédé de l'insémination consiste à déposer le sperme avec une seringue dans le vagin, le col ou l'utérus. Des taux de grossesse encore plus élevés ont été obtenus par le dépôt direct dans la trompe au moyen d'un tube guidé par échographie, mais cette technique n'est encore qu'expérimentale[159].

Le succès de l'insémination artificielle dépend de la synchronisation des différentes étapes. Puisque le spermatozoïde survit environ quarante-huit heures, une première insémination effectuée un ou deux jours avant le moment prévu pour l'ovulation et une autre quarante-huit heures plus tard devraient suffire à couvrir l'intervalle fertile[160]. Il est possible de prévoir le moment de l'ovulation avec une certaine précision au moyen de la courbe thermique, de la mesure échographique de la croissance folliculaire et du dosage des taux hormonaux[161].

2. Les résultats

Dans la plupart des études effectuées pour établir le taux de grossesse clinique dans les cas d'insémination artificielle hétérologue, on a utilisé des échantillons de sperme frais, c'est-à-dire non congelé. Les résultats sont alors comparables à ceux de l'insémination naturelle : environ 20 pour 100 par cycle, et près de 95 pour 100 après six cycles. Des études ont démontré que la congélation réduit de moitié la motilité, la longévité et la capacité de fécondation des spermatozoïdes. Les taux cumulés de grossesse représentent environ la moitié de ceux obtenus avec du sperme frais et, en moyenne, plusieurs cycles de traitement supplémentaires sont nécessaires pour provoquer une grossesse au moyen de sperme

156. Voir les commentaires à la note 185, *infra*.

157. N.J. Alexander et S. Ackerman, *loc. cit.*, note 39, 919.

158. Philip Rubin et Richard F. Bakemeier, *Clinical Oncology: A Multidisciplinary Approach*, 6e éd., New York, American Cancer Society, 1983, p. 352. Voir aussi D.J. Jones, *loc. cit.*, note 148, 527.

159. R.P.S. Jansen, *loc. cit.*, note 137, 72.

160. D.W. Keller, R.C. Strickler et J.C. Warren, *op. cit.*, note 29, p. 211 ; et J. Aiman, *loc. cit.*, note 154, 282.

161. J. Aiman, *loc. cit.*, note 154, 281-282.

congelé[162]. Le taux d'avortement spontané n'est cependant pas plus élevé avec l'usage de sperme congelé[163]. Comme pour les autres techniques de procréation médicalement assistée, l'âge et la fertilité de la femme ont une incidence sur le taux de grossesse[164].

Le taux de succès de l'insémination artificielle homologue dépend du motif pour lequel elle est pratiquée. Elle constitue la technique de fécondation la moins efficace si le sperme du partenaire constitue la source du problème[165]. En revanche, les chances de réussite sont élevées chez les couples dont l'infécondité est imputable à une anomalie anatomique masculine.

3. Les risques

Les principaux risques de l'insémination artificielle hétérologue sont les suivants : l'infection ; la transmission de maladies génétiques ; la consanguinité, si, dans un petit centre, on utilise trop souvent le sperme du même donneur[166] ; les erreurs administratives dans l'appariement du donneur et de la receveuse ; les risques inhérents à l'insémination intra-utérine.

Les risques d'infection augmentent lorsque le sperme est introduit dans le col ou l'utérus. Le sperme non traité peut contenir des micro-organismes sources de maladies infectieuses telles la blennorragie, la chlamydia ou le sida. La pratique de l'entreposage du sperme jusqu'à ce qu'un dépistage adéquat ait été effectué réduit les risques de transmission de ces maladies[167].

Parmi les effets secondaires de l'insémination intra-utérine, soit hétérologue, soit homologue, on constate souvent chez la femme des contractions utérines et, plus rarement, de l'hypotension artérielle, de la bradycardie et de la faiblesse. Des précautions médicales peuvent atténuer ces effets secondaires[168].

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162. La fédération française des CÉCOS (Centres d'études et de conservation du sperme humain) a recueilli des données sur environ 17 000 grossesses provoquées avec du sperme congelé. Le taux de succès par cycle est d'environ 8 pour 100, avec un taux de succès cumulé après 12 mois de 66 pour 100. Voir D. Le LANNOU et J. LANSAC, « Artificial Procreation with Frozen Donor Semen: Experience of the French Federation CÉCOS » (1989), 4:7 *Human Reprod.* 757, 759.

163. Jon ALFREDSSON, « Incidence of Spontaneous Abortion Following Artificial Insemination by Donor » (1988), 33:4 *Int. J. Fertil.* 241, 244.

164. D. Le LANNOU et J. LANSAC, *loc. cit.*, note 162, 760. Voir aussi Christopher L.R. BARRATT, Mayur CHAUHAN et Ian D. COOKE, « Donor Insemination — A Look to the Future » (1990), 53:3 *Fertil. Steril.* 375, 382.

165. R.F. SPARK, *op. cit.*, note 29, p. 336. Voir aussi la note 40, *supra*.

166. Si l'on utilise trop souvent le sperme du même donneur, il pourrait, en théorie, arriver que des descendants liés biologiquement à leur insu se rencontrent et procréent, ce qui pourrait entraîner des anomalies génétiques chez leurs descendants. Selon des calculs, ce risque est en fait très bas (moins de 1 pour 1000). J. AIMAN, *loc. cit.*, note 154, 284. Le risque de consanguinité dépend de la taille de la collectivité desservie par le centre.

167. Voir le texte sous la rubrique « La sélection des gamètes et des embryons », *infra*, p. 37.

168. Les effets secondaires peuvent souvent être corrigés au moyen d'aspirine. Voir J. AIMAN, *loc. cit.*, note 154, 284.

La sélection adéquate des donneurs, sur laquelle nous reviendrons plus à fond, diminue les risques de transmission des maladies génétiques, dans la mesure où elle permet au couple d'apprécier, avant d'accepter, les risques auxquels est exposé l'enfant devant naître de l'intervention. Par ailleurs, le retrait des donneurs après un certain nombre de dons réduit les risques de consanguinité. Plus la collectivité est petite, moindre est le nombre de fois où un individu devrait être admis à donner son sperme.

4. Le donneur

La pratique habituelle consiste à ne pas dévoiler à la receveuse l'identité du donneur. Les étudiants en médecine et autres étudiants universitaires agissent souvent comme donneurs de sperme, probablement en raison du fait que les cliniques de fertilité sont généralement situées à proximité des universités. À certains endroits, cependant, les donneurs sont sollicités au moyen d'annonces dans les médias[169]. Les centres canadiens exploitent en général leur propre banque de sperme ; il leur arrive à l'occasion d'importer du sperme d'endroits comme New York et la Californie[170].

E. Le don d'ovule et d'embryon

Le don d'ovule devient une solution de plus en plus intéressante en cas de stérilité imputable, par exemple, à une ménopause précoce. De fait, en 1987, dix-sept centres américains ont déclaré avoir recours aux dons d'ovule pour l'application des techniques de fécondation in vitro ou d'implantation tubaire de gamètes, comparativement à un seul centre en 1985-1986[171]. Le don d'ovule est surtout indiqué en cas d'absence ou de dysfonction des ovaires, ou lorsque la femme est porteuse du gène d'une affection génétique[172].

Le don d'embryon consiste dans le transfert d'un embryon n'ayant aucun lien génétique avec le couple receveur. Cet embryon peut être donné par le couple qui a eu recours à la fécondation in vitro et qui a produit un nombre d'embryons trop élevé pour ses besoins personnels.

La congélation d'embryons résout certains dilemmes d'ordre éthique pour la médecine et le droit, tout en en créant d'autres. Ainsi, elle reporte le problème des embryons surnuméraires, mais ne le supprime pas : s'ils ne sont pas utilisés, il faudra tôt ou tard

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169. Société canadienne de fertilité et d'andrologie, *op. cit.*, note 11, p. 5.

170. Voir le *Rapport sur le sperme humain de 1981*, *op. cit.*, note 149, p. 13 et suiv.

171. *U.S. IVF/ET 1989*, *loc. cit.*, note 75, 17. Voir aussi Medical Research International and American Fertility Society Special Interest Group, « In Vitro Fertilization/Embryo Transfer in the United States: 1985 and 1986 Results from the National IVF/ET Registry » (1988), 49:2 *Fertil. Steril.* 212, 214 (ci-après *U.S. IVF/ET 1988*).

172. J. Leeton, A. Trounson et C. Wood, « The Use of Donor Eggs and Embryos in the Management of Human Fertility » (1984), 24:4 *Aust. N.Z. J. Obstet. Gynaec.* 265.

en disposer. Les principaux avantages de la congélation d'embryons sont les suivants : le procédé permet de limiter le nombre d'embryons réimplantés dans un cycle de fécondation in vitro, et de réduire ainsi le risque de grossesse multiple ; il permet, en cas d'échec du premier cycle de fécondation in vitro, de faire plus tard d'autres tentatives au cours de cycles naturels, sans autre prélèvement d'ovocytes ; il permet de mettre sur pied des programmes plus simples de don d'embryon.

Au début de son développement, le zygote peut supporter des dommages cellulaires limités au cours du processus de congélation et de décongélation, puisque toutes les cellules sont, à ce stade, aptes à former un embryon. Par conséquent, l'embryon congelé au stade des quatre cellules peut survivre à la décongélation avec seulement trois cellules, tout en conservant un potentiel de développement normal[173].

1. La technique

Nous avons décrit dans le présent chapitre le procédé général de la ponction d'ovocytes[174]. Certains auteurs font mention de méthodes de prélèvement par lavage, même si elles ne sont pas utilisées au Canada. Il s'agit de soumettre la donneuse à une stimulation ovarienne, avec ou sans insémination, puis d'expulser les ovules ou les embryons de l'utérus à l'aide d'une solution[175].

Dans les cas où les cycles ovulatoires de la receveuse sont normaux, ils doivent être synchronisés avec ceux de la donneuse, afin que la paroi utérine de la receveuse soit prête pour l'implantation. Si ses cycles ne sont pas normaux, comme dans le cas d'une ménopause précoce, on administre des hormones pour simuler un cycle normal. Au moment du transfert des embryons ou des gamètes, les niveaux hormonaux de la receveuse doivent être suffisants pour permettre l'implantation ; ils doivent être maintenus ainsi jusqu'à ce que le placenta de l'embryon en cours de développement produise lui-même les hormones de grossesse, soit environ huit à douze semaines plus tard[176].

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173. A. Trounson, *loc. cit.*, note 118, 140. Une étude internationale effectuée dans 24 centres et terminée en décembre 1986 a démontré que, sur 3 577 embryons congelés, environ 50 pour 100 pouvaient être réimplantés. Le taux de grossesse par transfert a été établi à 13 pour 100 et le taux d'avortement spontané à 26 pour 100. Le taux d'accouchement n'est pas clair, les auteurs n'ayant fait aucune distinction entre les grossesses unipares et les grossesses multipares. André C. Van Steirteghem et Etienne Van Den Abbeel, « Survey on Cryopreservation » (1988), 541 *Ann. N.Y. Acad. Sci.* 571. Pour plus de renseignements sur le taux de succès des grossesses obtenues par l'implantation d'embryons congelés, voir Jacques Testart, « Results of In Vitro Fertilization With Embryo Cryopreservation and a Recommendation for Uniform Reporting » (1988), 49:1 *Fertil. Steril.* 156.

174. *Supra*, pp. 15-16.

175. Mark V. Sauer, Robert E. Anderson et Richard J. Paulson, « A Trial of Superovulation in Ovum Donors Undergoing Uterine Lavage » (1989), 51:1 *Fertil. Steril.* 131. La méthode du don d'embryon au moyen de la stimulation ovarienne, de l'insémination et du lavage est jugée inacceptable dans certains pays, en raison du risque important de grossesse non désirée auquel s'expose la donneuse. Voir P.A.W. Rogers et autres, « Oocyte Donation », dans C. Wood et A. Trounson (dir.), *op. cit.*, note 52, p. 143, à la page 146.

176. P.A.W. Rogers et autres, *loc. cit.*, note 175, 148-151.

2. La donneuse d'ovule

Le type de la donneuse d'ovule se trouve généralement dans l'une ou l'autre des catégories suivantes : la femme qui se soumet à une ponction d'ovocytes pour ses propres besoins de procréation, celle qui subit une stérilisation, la donneuse volontaire anonyme, la donneuse connue (amie ou parente sollicitée par la receveuse)[177].

Le procédé de stimulation ovarienne et de prélèvement d'ovocytes comporte de légers risques médicaux. Quant à savoir si ces risques sont raisonnables dans le cas d'un don pour motifs purement altruistes, la question reste controversée. En théorie, la meilleure candidate au don d'ovule est probablement celle qui subit l'intervention pour ses propres besoins, lorsque le nombre d'ovules prélevés est supérieur à ce qui lui est nécessaire. Là où des installations de cryoconservation sont disponibles, toutefois, il est probable que le couple préférera faire féconder les oeufs qui restent et congeler les embryons en vue d'un usage personnel futur[178]. L'intérêt pratique de cette hypothèse est donc limité.

On a souvent recours à une donneuse connue[179]. Les auteurs invitent toutefois à la prudence : l'avenir des relations psychologiques entre l'enfant, la mère et la donneuse constitue un aspect important à considérer[180]. De plus, si le motif du don est de prévenir la transmission d'affections génétiques, le recours à une parente est sujet à caution. Enfin, lorsqu'il s'agit d'éviter des risques importants d'anomalies génétiques dus à la consanguinité, la sœur du mari est une donneuse contre-indiquée, à moins que le sperme utilisé provienne d'un donneur.

Le dernier groupe de donneuses types est celui des femmes qui se font stériliser volontairement[181]. Puisqu'elles ont déjà décidé de subir l'intervention radicale que constitue la stérilisation, le seul risque qu'elles courent est celui que comporte la stimulation ovarienne.

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177. *Id.*, 145-146.

178. La congélation des ovules n'est pas encore une pratique courante, quoique quatre enfants soient nés dans le monde grâce à des ovules qui avaient été congelés. L'oeuf humain est particulièrement vulnérable aux dommages qui peuvent survenir au cours du processus de congélation et de décongélation. Le risque réside dans une anomalie au cours de la division cellulaire subséquente, laquelle peut entraîner un nombre anormal de chromosomes ; le revêtement protecteur entourant l'ovule peut aussi être endommagé, ce qui permet à plus d'un spermatozoïde de le féconder. De plus amples études sont nécessaires dans ce domaine pour connaître l'avenir de la congélation de l'oeuf humain. A. TROUNSON, *loc. cit.*, note 118, 138-139. Voir aussi Christopher CHEN, « Pregnancies after Human Oocyte Cryopreservation » (1988), 541 *Ann. N.Y. Acad. Sci.* 541, 547.

179. Mark V. SAUER et autres, « Survey of Attitudes Regarding the Use of Siblings for Gamete Donation » (1988), 49:4 *Fertil. Steril.* 721.

180. Voir à ce sujet ILA, *op. cit.*, note 76, p. 15. Au terme d'une rencontre multidisciplinaire portant sur le don d'ovule, l'organisme a décidé que, tout comme les donneurs de sperme, les donneuses d'ovule devraient demeurer anonymes (*Authority's Guideline* 13(j), *id.*, p. 47).

181. P.A.W. ROGERS et autres, *loc. cit.*, note 175, 146. Ce groupe de donneuses présente un autre avantage : leur fertilité a, dans la plupart des cas, déjà été démontrée.

F. La maternité de substitution

Dans le présent contexte, la femme porteuse est celle qui consent à mener à terme une grossesse avec l'intention de remettre le nouveau-né aux parents « sociaux » ou « contractuels ». Indépendamment des questions d'ordre éthique et juridique importantes que soulève ce phénomène, il convient d'analyser les circonstances dans lesquelles la maternité de substitution pourrait être indiquée[182] : l'utérus présente une anomalie importante ou est absent (la maternité de substitution est alors la seule façon de procréer) ; le milieu dans lequel se développe le fœtus risque d'être néfaste à ce dernier (par exemple lorsque la mère doit, pour sa propre santé, prendre continuellement des médicaments nuisibles au fœtus) ; la grossesse présente un danger considérable pour la santé de la mère, par exemple si elle souffre de cardiopathie grave. Les deux derniers types de situation évoquent la nécessité d'un environnement plus sûr pour la grossesse, mais ne sont pas considérés comme des indications absolues.

Il existe plusieurs combinaisons possibles de liens entre la femme porteuse et les futurs parents. L'ovule peut provenir de la femme porteuse[183] ou de la mère sociale, ou encore être donné par une tierce personne. Le sperme peut être celui du père social ou d'un donneur. En tout, six combinaisons de filiation biologique sont possibles.

Presque aussi nombreuses, les techniques de fécondation utilisées peuvent être classées en deux catégories : la fécondation in vitro et la fécondation in vivo, notamment l'implantation tubaire de gamètes, l'insémination artificielle et l'insémination naturelle. La fécondation in vitro et l'implantation tubaire sont surtout utilisées dans les cas où l'ovule n'est pas fourni par la femme porteuse.

On considère parfois comme une variante de la maternité de substitution la technique (appelée *SET* en anglais) consistant à féconder in vivo, par insémination artificielle, l'ovule d'une donneuse, à recueillir l'embryon par lavage et à le transférer à la femme qui le portera ; quoi qu'il en soit, cette technique est examinée ici dans le contexte du don d'ovule et d'embryon[184].

V. La sélection des gamètes et des embryons

Le don de sperme constitue maintenant un palliatif bien accepté à l'infertilité ; avec la mise au point de techniques plus simples pour le prélèvement, le don d'ovule devrait

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182. Pour un examen des grossesses qui comportent des risques importants pour la mère ou le fœtus, voir J.A. PRITCHARD, P.C. MACDONALD et N.F. GANT, *op. cit.*, note 89, pp. 494, 592, 608, 802.

183. Dans le présent document, nous appellerons « mère de substitution » la femme porteuse qui, en fournissant l'ovule, se trouve être également la mère génétique ou biologique de l'enfant faisant l'objet du contrat.

184. Voir *supra*, note 175.

aussi devenir plus courant. Pour la receveuse, le risque principal du don de gamètes est la transmission de maladies infectieuses. Pour l'enfant, les risques comprennent à la fois les maladies infectieuses (tel le cytomégalovirus) et les affections génétiques. Quoique les avantages du dépistage des maladies infectieuses et génétiques aient été largement diffusés et prônés mondialement, il est encore permis de craindre que certaines cliniques se montrent réfractaires aux recommandations de contrôle[185] établies par les organismes professionnels tels l'American Fertility Society[186] et la Société canadienne de fertilité et d'andrologie[187].

La possibilité, même très mince, que le virus du sida soit transmis par du sperme donné a entraîné la prise de recommandations rigoureuses, suivant lesquelles le sperme de tout donneur au Canada doit être congelé et entreposé pendant au moins six mois, jusqu'à ce que le donneur soit à nouveau soumis à une épreuve de dépistage du virus. Ce processus est nécessaire parce que la présence du virus dans le sang du donneur peut ne pas être décelable pendant un certain temps[188].

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185. Une étude américaine terminée en 1987 auprès de 11 000 médecins participant à des programmes d'insémination artificielle hétérologue a démontré qu'un cinquième des centres ne vérifiaient pas la présence de maladies transmises sexuellement chez les donneurs et que moins de la moitié effectuaient des épreuves de dépistage des maladies génétiques. Par ailleurs, parmi ceux qui effectuaient ces épreuves, plusieurs ne le faisaient pas correctement : par exemple, dans certains cas, des donneurs ont été rejetés sans raison alors que dans d'autres, ils ont été acceptés malgré l'existence d'un risque important. Voir OTA, *Artificial Insemination: Practice in the United States*, Washington (D.C.), OTA, 1988, pp. 8, 33-40. Une étude de la Commission de réforme du droit de l'Ontario réalisée en 1984 auprès de 16 médecins pratiquant des inséminations artificielles hétérologues en Ontario a révélé que les pratiques de sélection des donneurs varient considérablement. Voir CRDO, *op. cit.*, note 2, p. 22, n. 36-38. Voir aussi C.L.R. BARRATT, M. CHAUHAN et I.D. COOKE, *loc. cit.*, note 164.

186. THE AMERICAN FERTILITY SOCIETY, « New Guidelines for the Use of Semen Donor Insemination: 1990 » (1990), 53:3 (suppl. 1) *Fertil. Steril.* 1S et suiv., voir également *infra*, note 190.

187. SOCIÉTÉ CANADIENNE DE FERTILITÉ ET D'ANDROLOGIE, *op. cit.*, note 11, p. 3. La Société a adopté en 1988 des normes et principes directeurs pour l'insémination thérapeutique hétérologue, dans lesquels elle déclare : « Une attention soutenue aux divers aspects de l'examen et du suivi des donneurs permettra de réduire au minimum les risques de transmission de maladies génétiques ou autres. Il est possible d'y arriver en s'appuyant sur les connaissances et les techniques les plus sûres. »

188. La littérature fait état de six cas d'infection par le virus VIH à la suite d'insémination au moyen de sperme congelé (4 en Australie et 2 au Canada). Voir SANTÉ ET BIEN-ÊTRE SOCIAL CANADA, CENTRE FÉDÉRAL SUR LE SIDA, « Lignes de conduite pour la prévention de l'infection à VIH dans la transplantation d'organe et de tissu » (octobre 1989), 15S4 (suppl.) *Rapport hebdomadaire des maladies au Canada* 1, 2. Un rapport plus récent provenant de la ville de New York révèle que le sperme de six hommes porteurs du virus du sida a été utilisé pour inséminer 178 femmes, dont une a récemment été déclarée séropositive. À ce sujet, voir Mary Ann CHIASSON, Rand L. STONEBURNER et Stephen C. JOSEPH, « Human Immunodeficiency Virus Transmission through Artificial Insemination » (1990), 3 *J. Acquired Immune Deficiency Syndrome* 69. Voir aussi SOCIÉTÉ CANADIENNE DE FERTILITÉ ET D'ANDROLOGIE, *op. cit.*, note 11, p. 3, où la Société déclare : « à cause des risques associés à son usage en ITSD [insémination thérapeutique avec sperme de donneur], le sperme frais ne saurait convenir dans les conditions actuelles. La cryoconservation du sperme doit donc s'effectuer dans un cadre assurant un contrôle rigoureux des donneurs en regard de la menace du SIDA, de sorte que seul le sperme préalablement conservé pendant au moins six mois puisse servir en ITSD ». Voir aussi Edwin P. PETERSON, Nancy J. ALEXANDER et Kamran S. MOGHISSI, « A.I.D. and AIDS: Too Close for Comfort » (1988), 49:2 *Fertil. Steril.* 209 ; C.L.R. BARRATT, M. CHAUHAN et I.D. COOKE, *loc. cit.*, note 164.

Parmi les autres maladies infectieuses qui devraient donner lieu à des contrôles, par culture de sperme ou analyses sanguines, mentionnons l'hépatite, le cytomégalovirus, l'herpès, la blennorragie, la chlamydia et le mycoplasme[189]. Une vérification attentive du genre de vie et des antécédents médicaux et sexuels des donneurs réduit aussi le risque de transmission des maladies infectieuses, les donneurs à risque élevé pouvant alors être écartés[190].

Bien que l'on ignore encore si les micro-organismes en cause peuvent être transmis par l'ovule, les donneuses devraient être soumises aux mêmes épreuves de dépistage que les donneurs de sperme[191]. Comme la congélation d'ovules n'est pas encore très répandue[192], le délai entre le don et l'acceptation de l'ovule par la receveuse est limité. Par conséquent, un contrôle rapide et aussi poussé que possible s'impose pour assurer la sécurité de la receveuse et de sa grossesse éventuelle[193]. Le risque de transmettre une maladie génétique par le don d'ovule est aussi élevé, sinon davantage, que par le don de sperme, en raison du danger supplémentaire que représentent les maladies liées au chromosome X. Il est donc important, malgré les contraintes de temps, que les lignes directrices prescrites pour le dépistage des maladies génétiques soient rigoureusement observées, afin que la receveuse soit en mesure de prendre une décision bien informée au chapitre des risques en jeu[194].

Le don d'embryon exige en plus le contrôle génétique complet des deux parents, ce qui représente un fardeau supplémentaire, mais nécessaire. Idéalement, ces données devraient être conservées dans des registres pour pouvoir être consultées si une anomalie est décelée à la naissance ou si une affection génétique se manifeste plus tard[195]. La même rigueur dans le dépistage des maladies transmises sexuellement et des maladies génétiques devrait s'appliquer à la maternité de substitution.

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189. Société canadienne de fertilité et d'andrologie, *op. cit.*, note 11, p. 6, n° 4.

190. Voir *id.*, p. 5, n° 2 ; Ruth M. Greenblatt et autres, « Screening Therapeutic Insemination Donors for Sexually Transmitted Diseases: Overview and Recommendations » (1986), 46:3 *Fertil. Steril.* 351.

191. The American Fertility Society, The Ethics Committee, « Ethical Considerations of the New Reproductive Technologies » (1986), 46:3 (suppl. 1) *Fertil. Steril.*

192. Voir *supra*, note 178.

193. Pour un examen détaillé de la question du dépistage, voir P. Jalbert et autres, *loc. cit.*, note 154, 269-275 ; F. Clarke Fraser et R. Allan Forse, « On Genetic Screening of Donors for Artificial Insemination » (1981), 10 *Am. J. Med. Genet.* 399 ; Société canadienne de fertilité et d'andrologie, *op. cit.*, note 11, p. 18 ; voir également The American Fertility Society, *loc. cit.*, note 186.

194. Le Collège canadien des généticiens médicaux s'emploie actuellement à élaborer des lignes directrices pour le dépistage des maladies génétiques chez les donneuses d'ovule (communication privée avec le D[r] F.C. Fraser).

195. Les auteurs font valoir qu'en cas de don de gamètes ou d'embryon, il peut s'avérer important de tenir des dossiers (en utilisant des codes pour protéger l'anonymat des donneurs et des receveuses) permettant d'avertir le donneur en cas d'anomalie chez l'enfant. Selon l'un des rapports, la notification est opportune lorsque la maladie est grave, qu'elle risque de se reproduire chez les descendants et qu'elle peut être évitée. Voir P. Jalbert et autres, *loc. cit.*, note 154, 272. Il semble que la notification des donneurs devrait faire l'objet de plus amples études.

Pour souligner l'importance de ce qui précède, prenons l'exemple de la femme porteuse qui, à l'insu des parents sociaux, est porteuse du virus VIH. Plus tard, on découvre que le nouveau-né est également séropositif. Ni les parents sociaux ni la femme porteuse ne veulent garder l'enfant. En l'occurrence, bien que la femme porteuse fût la sœur de la mère sociale, elle n'avait pas révélé qu'elle était toxicomane et donc exposée à des risques élevés de contracter la maladie[196]. Cela prouve que, même si le donneur est connu, il est important d'effectuer les contrôles appropriés, et met en évidence les risques qu'une carence à cet égard fait courir à l'enfant.

196. Winston R. FREDERICK et autres, « HIV Testing of Surrogate Mothers » (1987), 317:21 *New Eng. J. Med.* 1351 (lettre).

TABLEAU I : Résultats internationaux de la fécondation in vitro

Pays	Nombre de cycles hormonaux (CH)	Nombre de couples traités (CT)	Nombre de transferts d'embryon (TE)	Nombre de grossesses cliniques (GC)	GC/CH	GC/CT	Nombre d'avortements spontanés (AS)	AS/GC	Nombre de grossesses ectopiques (GE)	GE/GC	Nombre d'accouchements (A)	A/CH	Nombre de naissances vivantes (NV)	NV/CH	Nombre de naissances multiples (NM)	NM/A
Canada																
1982–1988	5 921	3 277	4 474	667	11,3%	20,4%	150	22,5%	47	7%	—	—	460	7,9%	—	—
Royaume-Uni																
1988	10 489	7 515	6 553	1 354	12,9%	18%	264	19,5%	69	5%	—	—	956	9%	—	24%
Australie et Nouvelle-Zélande																
1986	4 507	—	—	612	13,6%	—	159	26%	36	5,8%	417	9,3%	—	—	—	—
1979–1985	—	—	—	1 259	—	—	—	24,3%	65	5,2%	902	—	1 138	—	—	22,4%
États-Unis																
1987	—	—	7 561	1 367	—	—	344	25%	103	7,5%	991	—	1 260	—	—	24%
1986	4 867	3 055	2 864	485	10%	16,9%	151	31,1%	22	4,5%	—	—	311	6,4%	—	—

Sources : Canada : S.E. BROWN, *loc. cit.*, note 80, 28, 31. **Royaume-Uni :** *The Fifth Report of the Interim Licensing Authority for Human In Vitro Fertilisation and Embryology 1990, op. cit.*, note 76, pp. 20-22. **Australie et Nouvelle-Zélande : 1986 :** F.J. STANLEY, *loc. cit.*, note 70, 425 ; **1979-85 :** AUSTRALIAN IN-VITRO FERTILIZATION COLLABORATIVE GROUP, *loc. cit.*, note 74, 429-436. **États-Unis : 1987 :** MEDICAL RESEARCH INTERNATIONAL AND THE SOCIETY OF ASSISTED REPRODUCTIVE TECHNOLOGY, *loc. cit.*, note 75, 13-18 ; **1986 :** MEDICAL RESEARCH INTERNATIONAL AND AMERICAN FERTILITY SOCIETY SPECIAL INTEREST GROUP, *loc. cit.*, note 171, 213-214.

TABLEAU II : Résultats internationaux de l'implantation tubaire de gamètes (GIFT)

Pays	Nombre de traitements GIFT	Nombre de grossesses cliniques (GC)	GC/GIFT	Nombre d'avortements spontanés (AS)	AS/GC	Nombre de grossesses ectopiques (GE)	GE/GC	Nombre d'accouchements (A)	A/GIFT	Nombre de naissances vivantes (NV)	Nombre de naissances multiples (NM)	NM/A
Royaume-Uni 1988	3 392	707	21%	—	—	—	—	—	—	—	139	20%
Australie 1986	607	136	22%	21	15%	7	5%	108	18%	—	—	—
États-Unis 1987	1 968	492	25%	116	24%	30	6%	362	18%	489	103	28%

Sources : Royaume-Uni : *The Fifth Report of the Interim Licensing Authority for Human In Vitro Fertilisation and Embryology 1990*, *op. cit.*, note 76, pp. 20-22. **Australie :** H.W. JONES, Jr. et P.A.W. ROGERS, *loc. cit.*, note 73, 60. **États-Unis :** MEDICAL RESEARCH INTERNATIONAL AND THE SOCIETY OF ASSISTED REPRODUCTIVE TECHNOLOGY, *loc. cit.*, note 75, 16.

TABLEAU III : Effets sur la grossesse du nombre d'embryons transférés

Nombre d'embryons transférés	Australie et Nouvelle-Zélande (1979 – 1985)		Royaume-Uni (1988)		Canada (1984 – 1987)	
	% de grossesse clinique	% de grossesse multiple	% de grossesse clinique	% de grossesse multiple	% de grossesse clinique	% de grossesse multiple
1	—	1	9,6	1	11	0
2	—	12	14,2	13,1	12	11
3	—	33	25,2	29,2	20	20
4	—	30	23,4	24,2	22	15
5	—	13	—	—	24	29

Sources : Canada : A. A. YUZPE et autres, *loc. cit.*, note 66, 169. **Royaume-Uni :** *The Fifth Report of the Interim Licensing Authority for Human In Vitro Fertilisation and Embryology 1990*, *op. cit.*, note 76, p. 24. **Australie et Nouvelle-Zélande :** Paul A. L. LANCASTER, « How Many Oocytes/Embryos Should Be Transferred? » (1987), II:8550 *Lancet* 109, 110 (lettre).

CHAPITRE DEUX

Les interrogations du droit canadien

De façon générale, nous pouvons affirmer que le droit canadien s'adapte difficilement aux diverses situations que rend possible la procréatique. Dans ce deuxième chapitre, nous allons donc exposer les principaux problèmes que cette technologie pose au droit. L'ampleur de la tâche apparaît évidente lorsqu'on constate la variété des branches du droit et des textes de lois — tant fédéraux que provinciaux — qui entrent en jeu. Le cadre juridique dans lequel évolue la procréation médicalement assistée est en effet très large. Il est constitué de diverses notions, principes et branches du droit tels que l'ordre public, le principe de la non-disponibilité du corps humain pour le commerce[197], le droit à la vie, le droit à la liberté, la filiation, le droit des biens, le droit des contrats et le droit de la responsabilité. Afin de bien définir les problèmes posés au droit par la procréatique, nous étudierons les principales règles de droit applicables en la matière.

I. La procréatique et le droit privé

Comme nous le verrons, plusieurs aspects du droit privé intéressent la procréation médicalement assistée. Ainsi, nous étudierons les règles qui régissent le consentement, la filiation, les successions, les contrats, les biens et la responsabilité, ainsi que leurs effets sur le recours à l'insémination artificielle, à la fécondation in vitro, à l'implantation tubaire de gamètes et au prélèvement d'embryon par lavage utérin. Puisque les parents potentiels, le donneur éventuel, l'enfant et les intervenants médicaux sont les principales personnes touchées par les problèmes juridiques que soulèvent ces techniques, c'est sous l'angle de chacun de ces protagonistes que nous allons procéder à notre analyse des règles du droit privé.

A. Les parents potentiels

1. Le consentement

La décision d'avoir un enfant est une décision privée qui reflète normalement, dans le cadre d'une union maritale, la volonté d'un couple. Or, la procréatique permet à la

197. Voir *infra*, p. 47 et suiv.

femme de concevoir un enfant sans l'intervention de son partenaire, d'où le problème de l'attribution de la paternité à un homme qui n'est pas génétiquement lié à l'enfant et qui n'a pas consenti à la conception[198]. Indépendamment des recours dont dispose le partenaire (séparation, divorce, désaveu)[199], nous pouvons nous interroger sur l'opportunité d'une intervention spécifique du législateur. Notre droit devrait-il exiger le consentement des deux conjoints comme condition d'accès aux différentes techniques de procréation médicalement assistée ?

Les difficultés que poserait une telle intervention sautent aux yeux. La reconnaissance au mari d'un droit de regard sur la conception d'un enfant se heurte en effet au droit de la femme de disposer de son propre corps ainsi qu'à son autonomie en matière de procréation[200].

À l'heure actuelle, seuls le Québec, le Yukon et Terre-Neuve se sont dotés de dispositions relatives au consentement en matière de procréation médicalement assistée, sans toutefois en prévoir la forme. L'article 586 du *Code civil du Québec* (C.c.Q.) se lit ainsi :

> Le recours en désaveu ou en contestation de paternité n'est pas recevable si l'enfant a été conçu par insémination artificielle, soit des œuvres du mari, soit des œuvres d'un tiers, du *consentement* des époux [mis en italique par nos soins][201].

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198. Nous visons ici le cas où l'enfant est conçu grâce aux gamètes d'une tierce personne, le sperme du conjoint ne pouvant être utilisé sans son consentement.

199. Michèle RIVET, « Quand la médecine intervient dans la genèse de la conception, que fait le droit ? Ou le délicat problème de l'insémination artificielle », dans ASSOCIATION HENRI CAPITANT, *Le corps humain et le droit : Journées Belges*, t. 26, Paris, Dalloz, 1977, p. 87, à la page 95 : « [L]'insémination artificielle sans le consentement du mari ne constitue pas un adultère mais constitue en soi une offense matrimoniale qui devrait être sanctionnée en elle-même, qu'il s'agisse d'IAD ou d'IAH. » Jean-Louis BAUDOUIN, « Aspects juridiques », dans Marcel J. Melançon (dir.), *L'insémination artificielle thérapeutique*, Québec, P.U.L., 1983, p. 113, à la page 121 :

> [D]ans tous les systèmes juridiques, les époux, de par leur mariage, assument l'un envers l'autre l'obligation de fidélité, de secours et d'assistance. Il est donc tout à fait logique, dans cette perspective, d'admettre qu'une hétéro-insémination pratiquée à l'insu du mari puisse constituer dans les faits une rupture de ces obligations et devenir une cause de divorce ou de séparation de corps, au titre général de « sévices et injures graves », de « cruauté mentale », ou « d'atteinte irrémédiable à la volonté de maintenir le lien du mariage.

200. Certains voient dans l'exigence du consentement du mari une contradiction avec la législation en matière de santé. Voir à ce sujet Bartha Maria KNOPPERS, *Conception artificielle et responsabilité médicale*, Cowansville (Qc), Yvon Blais, 1986, p. 96 ; en matière de consentement au traitement médical ou d'obtention de services médicaux, le respect de l'autonomie de la personne prime. En conséquence, si la personne est en mesure de manifester sa propre volonté, le consentement de son conjoint ne peut être exigé pour l'administration de ces soins. Voir également Ellen I. PICARD, *Legal Liability of Doctors and Hospitals in Canada*, 2e éd., Toronto, Carswell, 1984, pp. 62-63. Au Québec, l'art. 156 de la *Loi sur les services de santé et les services sociaux*, L.R.Q., ch. S-5, stipule que « [l]e consentement du conjoint ne peut être exigé pour la prestation de services dans un établissement ». Voir également les art. 19, 19.1 à 19.4 du *Code civil du Bas Canada* (C.c.) et l'art. 10 et suiv. du *Code civil du Québec*, projet de loi 125 (1re lecture, 18 décembre 1990), 1re session, 34e législature (Québec), (ci-après projet de loi 125). Pour l'Ontario, voir la *Loi de 1986 sur le droit de la famille*, L.O. 1986, ch. 4, par. 64(2) : « Il est reconnu à la personne mariée la même capacité juridique à toute fin et en toute matière que si elle n'était pas mariée ».

201. Le projet de loi 125, précité, note 200, reprend ces principes à l'art. 580 :

> Nul ne peut contester la filiation de l'enfant pour une raison tenant au caractère médicalement assisté de sa procréation et l'enfant n'est pas recevable à réclamer un autre état.

D'aucuns voient dans cette disposition l'exigence du consentement du mari. À la lecture de l'article, cependant, ce consentement n'est rien d'autre qu'une fin de non-recevoir au recours en désaveu et en contestation de paternité en cas de litige portant sur des questions de filiation, de divorce ou de succession[202]. Il ne s'agit donc pas de reconnaître un pouvoir décisionnel au mari mais plutôt d'assortir de conséquences son consentement à l'insémination[203], en l'empêchant d'arguer de l'absence de lien biologique pour désavouer un enfant dont il a voulu la conception. Nous reviendrons d'ailleurs sur cette question.

Les recours qui s'offrent au mari[204] et l'importance du droit de la femme de disposer de son propre corps ainsi que son autonomie en matière de procréation amènent la Commission à conclure qu'il n'y a pas lieu d'exiger le consentement du mari en matière de procréation médicalement assistée.

Il est important de mentionner que la question du consentement des deux futurs parents peut être posée dans une autre perspective, celle de l'opportunité de protéger légalement la biparentalité hétérosexuelle de la cellule familiale. En effet, exiger le consentement des deux futurs parents aurait pour conséquence d'empêcher les personnes seules et les couples homosexuels de recourir à la procréation médicalement assistée. Il est évident qu'une telle

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Cependant, le mari de la mère peut désavouer l'enfant ou contester la reconnaissance s'il n'a pas consenti à la procréation médicalement assistée ou s'il prouve que l'enfant n'est pas issu de celle-ci.

Pour le Yukon, voir *Children's Act*, R.S.Y.T. 1986, ch. 22, par. 13(3) à 13(5). Le par. 13(3) se lit ainsi : [TRADUCTION] « L'homme qui est marié à une femme au moment où elle est inséminée artificiellement avec le sperme d'un autre homme seulement est réputé en droit être le père de l'enfant né de l'insémination s'il a consenti à l'avance à l'insémination. » Pour Terre-Neuve, voir, au même effet, *The Children's Law Act*, S.N. 1988, ch. 61, par. 12(3).

202. Les dispositions du Yukon et de Terre-Neuve se trouvent sous la rubrique « Establishment of Parentage ».

203. Nous retrouvons d'ailleurs une position analogue à l'art. 11.2 du *An Act to amend the Uniform Child Status Act*, adopté en août 1991 (ci-après loi modifiant la loi uniforme sur le statut de l'enfant) et modifiant le *Uniform Child Status Act* (1980), CONFÉRENCE SUR L'UNIFORMISATION DES LOIS AU CANADA, *Consolidation of Uniform Acts*, Frédéricton (N.-B.), la Conférence (révision permanente), p. 5-1 (ci-après loi uniforme sur le statut de l'enfant).

[TRADUCTION]
11.2. Par dérogation au paragraphe 6(3), dans le cas d'un enfant né, avant ou après l'entrée en vigueur du présent article, à la suite d'une procréation assistée, la présomption de paternité prévue à l'article 9 ne peut être combattue que par la preuve de l'une ou l'autre des circonstances suivantes :

a) le père présumé :
(i) d'une part, n'est pas le père génétique de l'enfant,
(ii) d'autre part, n'a pas consenti à être le père d'un enfant conçu artificiellement ou a retiré son consentement avant la conception ;

b) lorsque le sperme utilisé pour la conception est celui du père présumé :
(i) d'une part, le père présumé n'a pas consenti à être le père d'un enfant conçu artificiellement ou a retiré son consentement avant la conception,
(ii) d'autre part, l'enfant n'a pas été conçu a la suite de rapports sexuels entre la mère et le père présumé.

204. Voir *supra*, p. 44.

mesure soulèverait, d'une part, d'importantes questions d'ordre constitutionnel et devrait, d'autre part, refléter un choix social entre certaines valeurs fondamentales. C'est là toute la question de l'accès aux différentes techniques de procréation médicalement assistée que nous étudierons en détail plus loin.

2. L'autorité sur les gamètes et les embryons

La personne ou le couple infertile qui a recours aux services d'une banque pour la conservation de ses gamètes ou de ses embryons entend normalement conserver la faculté exclusive d'en disposer[205]. Il faut toutefois s'interroger sur les fondements juridiques de cette faculté. Pourrait-il s'agir d'un droit de propriété ou de possession, ou encore d'une relation contractuelle (le respect du consentement et l'intention de la personne qui fait un dépôt) ? Dans trois arrêts, l'un rendu en France en 1984[206], les deux autres aux États-Unis en 1989 — *Davis*[207] et *York*[208] —, les tribunaux ont été appelés à statuer sur cette question. Nous nous intéresserons d'abord au dépôt de gamètes visé par l'arrêt français, puis nous verrons le sort réservé aux embryons dans les jugements américains.

En 1984, dans l'affaire *Parpalaix*[209], un tribunal français s'est vu saisi d'un litige opposant un centre d'étude et de conservation de sperme (CÉCOS) et la veuve d'un homme qui y avait déposé son sperme. Le centre refusait d'obtempérer à la demande de la veuve qui désirait récupérer le sperme en vue de subir une insémination artificielle. La demanderesse plaidait qu'un contrat de dépôt avait été conclu entre son mari et le CÉCOS.

Le juge a décidé que, en l'espèce, il ne s'agissait pas d'un contrat de dépôt mais plutôt d'un contrat innommé par lequel le CÉCOS s'engageait à conserver et à remettre le sperme, sur demande, soit au géniteur, soit à ses héritiers après son décès. Le juge s'est exprimé en ces termes :

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205. Nous verrons plus loin la situation du donneur ; voir *infra*, p. 53 et suiv.

206. Trib. gr. inst. Créteil, 1er août 1984, *Parpalaix* c. *C.E.C.O.S.*, Gaz. Pal. 1984.II.560.

207. *Davis* c. *Davis*, Cour de circuit, comté de Blount, Tennessee, n° E-14496 (21 septembre 1989), j. Young, pp. 1-2 ; cette décision a depuis été infirmée par 59 U.S.L.W. 2205 (Tenn. App. 1990). Voir *infra*, note 220 pour plus de détails.

208. *York* c. *Jones Institute*, 717 F. Supp. 421 (E.D. Va 1989) (la requête en irrecevabilité des défendeurs a été rejetée par une ordonnance en date du 10 juillet 1989). Voir *infra*, note 221 pour plus de détails. Il est à noter que les États-Unis et l'Australie ont également dû se pencher sur cette question dans l'affaire *Rios* : *In re Estates of Elsa and Mario Rios*, C.S. comté de Los Angeles, nos P680682, P680683 (mai 1985). La Cour supérieure de la Californie a décidé de ne pas nommer de tuteur pour les embryons et a déclaré qu'ils n'étaient ni les héritiers des Rios ni leur propriété. Voir à ce sujet, George P. SMITH, « Australia's Frozen "Orphan" Embryos : A Medical, Legal and Ethical Dilemma » (1985), 24 *J. Fam. L.* 27. Voir également Tamara L. DAVIS, « Protecting the Cryopreserved Embryo » (1990), 57 *Tenn. L. Rev.* 507, 518.

209. Précitée, note 206. Pour une étude intéressante de cette décision, voir D.J. JONES, *loc. cit.*, note 148.

> Les règles du contrat de dépôt telles qu'elles sont définies par les art. 1915 et s. C. civ. ne peuvent s'appliquer à la présente espèce qui concerne non pas une *chose tombant dans le « commerce »* mais une sécrétion contenant le germe de la vie et destinée à la procréation d'un être humain. [...]
>
> Il apparaît que la convention du 7 décembre 1981 constituait un contrat spécifique comportant pour le C.E.C.O.S. l'obligation de conservation et de restitution au donneur, ou de remise à celle à qui le sperme était destiné [mis en italiques par nos soins][210].

Le tribunal n'est cependant pas allé jusqu'à dire que le mari était propriétaire de ses gamètes. C'est plutôt sur la base de l'intention du défunt et de la non-stipulation de l'intention du CÉCOS de garder le sperme en cas de décès que le juge a ordonné la remise.

Dans cette décision, l'allusion faite par le juge aux choses ne tombant pas dans le commerce exige une précision. En droit civil, la chose hors du commerce est celle qui échappe à l'emprise de la volonté et qui ne peut être cédée, même gratuitement[211]. Le mot « commerce » a donc ici un sens particulier :

> [...] « un sens exceptionnel plus général que l'acceptation (sic) ordinaire. Il désigne non seulement les opérations commerciales proprement dites [...] mais tout acte juridique ayant pour but de créer, modifier ou éteindre des droits. Une chose hors du commerce est une chose qui ne peut faire l'objet d'actes juridiques accomplis par des particuliers ». Le commerce évoque l'idée d'une circulation des choses autour des personnes mais il n'est pas le synonyme du terme économique de « marché[212] ».

Cette définition extensive est, en partie, la source du scepticisme de certains auteurs français quant à l'inclusion du corps, de ses parties et de ses substances dans la catégorie des choses hors du commerce[213].

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210. *Parpalaix*, précité, note 206, 562.

211. Marie-Angèle HERMITTE, « Le corps hors du commerce, hors du marché » (1988), 33 *Arch. philo. dr.* 323, 325.

212. Jean-Christophe GALLOUX, « Réflexions sur la catégorie des choses hors du commerce : l'exemple des éléments et des produits du corps humain en droit français » (1989), 30 *C. de D.* 1011, 1015-1016.

213. M.-A. HERMITTE, *loc. cit.*, note 211, 327, est d'opinion que le corps lui-même n'est pas une chose hors du commerce. Commentant l'art. 1128 du Code civil français (le pendant de l'art. 1059 C.c.), elle écrit :

> Ce n'est donc pas le corps qui est ainsi protégé, placé hors de l'emprise des volontés par l'article 1128, mais la *personne*, abstraction juridique définie par des attributs, eux-mêmes abstraits, qui sont censés constituer la trame de la dignité humaine [...] cela montre par l'absurde que le droit civil ne s'intéresse au corps que comme support incident des représentations qui gravitent autour de la personne, définie par des références mouvantes aux bonnes mœurs, à la dignité, à la liberté. Ce n'est que lorsque l'atteinte au corps entraîne une atteinte à ces valeurs qu'elle est prise en considération.

Voir aussi J.-C. GALLOUX, *loc. cit.*, note 212, 1019, sur la portée limitée en droit français de la notion d'extra-commercialité concernant les produits et éléments du corps humain. Donnant l'exemple du sang, du lait maternel et des gamètes, il conclut : « [l]es produits humains circulent entre les personnes privées ou publiques ; ils ne demeurent pas, comme l'exigerait le statut de l'extra-commercialité, en la seule maîtrise de la personne d'où ils proviennent. »

Quoi qu'il en soit, en droit civil québécois, l'article 20 du *Code civil du Bas Canada* (C.c.) permet l'aliénation entre vifs de substances corporelles[214] et ce, même à titre onéreux. On peut donc en déduire que, dans la mesure où l'article 20 s'applique au sperme et aux ovocytes, les gamètes ne seraient pas des choses hors du commerce[215].

Il s'ensuit que l'article 1059 C.c., aux termes duquel « [i]l n'y a que les choses qui sont dans le commerce qui puissent être l'objet d'une obligation[216] », ne pourrait faire obstacle à la création de droits et d'obligations entre la banque et la personne qui dépose ses gamètes[217]. Les gamètes pourraient ainsi faire l'objet de contrats. Cependant, précisons que, dans ce contexte, la liberté contractuelle serait assujettie au critère de l'article 20 (la proportionnalité des risques[218]) ainsi qu'aux articles 13 et 990 C.c. (l'ordre public et les bonnes mœurs)[219].

En somme, le contrat entre la banque et la personne qui dépose ses gamètes serait donc source de droits et d'obligations pour les parties. En ce qui concerne les conjoints entre eux, il suffirait que chacun entretienne une relation contractuelle distincte avec la banque pour conserver une autorité exclusive sur ses gamètes. On se trouverait ainsi à éviter tout conflit concernant la disponibilité des gamètes du partenaire qui ne veut plus s'engager dans le projet parental pour quelque raison que ce soit. Cela dit, un problème supplémentaire se pose à l'égard de l'ovocyte. Puisque la congélation d'ovocyte semble poser des difficultés majeures, c'est l'ovocyte fécondé in vitro (l'embryon) qui est le plus souvent congelé. Une fois l'ovocyte fécondé, le pouvoir exclusif de chacun des conjoints sur ses gamètes doit céder la place à une forme de pouvoir partagé.

Que les gamètes utilisés soient ceux du couple ou proviennent d'un ou de deux donneurs, la question du pouvoir de disposer des embryons reste très épineuse. En cas de séparation, par exemple, il est possible que les deux conjoints réclament les embryons, ou encore que l'un d'entre eux s'oppose à leur utilisation. Nous devons donc nous doter des moyens de régler de tels conflits s'ils n'ont pas été prévus au contrat ou dans le formulaire de consentement signé par les géniteurs. Les décisions américaines *Davis* c.

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214. Jean-Louis BAUDOUIN et Catherine LABRUSSE-RIOU, *Produire l'homme : De quel droit ?*, Paris, P.U.F., 1987, p. 44, « En droit québécois, les dispositions ainsi adoptées s'appliquent non seulement aux organes eux-mêmes, mais aux substances corporelles (sang, sperme, etc.). » Voir également les art. 19 et 24 du projet de loi 125, précité, note 200. Toutefois, l'art. 25 du projet de loi ne fait plus de distinction entre les parties du corps susceptibles de régénération et celles qui ne le sont pas, en exigeant la gratuité dans tous les cas. L'article 25 se lit ainsi : « L'aliénation que fait une personne d'une partie ou de produits de son corps doit être gratuite ; elle ne peut être répétée si elle présente un risque pour la santé. »

215. J.-L. BAUDOUIN et C. LABRUSSE-RIOU, *op. cit.*, note 214, p. 115 : « Cette libéralisation ne se conçoit toutefois que dans une perspective thérapeutique ou, au moins, d'expérimentation scientifique menant à l'établissement d'un traitement. »

216. Voir aussi l'art. 1058 C.c.

217. En cas de conflit, le texte spécifique doit prévaloir sur le texte de portée générale. Pierre-André CÔTÉ, *Interprétation des lois*, Cowansville (Qc), Yvon Blais, 1982, p. 261.

218. Le risque couru ne doit pas être hors de proportion avec le bienfait que l'on peut espérer. Voir le texte de l'art. 20 C.c., *infra*, pp. 53-54.

219. Albert MAYRAND, *L'inviolabilité de la personne humaine*, Montréal, Wilson et Lafleur, 1975, p. 81.

Davis[220] et *York* c. *Jones Institute*[221], nous donnent un aperçu des litiges susceptibles de surgir et des difficultés que pose leur résolution.

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220. Précitée, note 207. L'absence de document ou de formule prévoyant la façon de disposer des embryons de M. et M^me^ Davis en cas de divorce a donné lieu à ce litige. Malgré le divorce, M^me^ Davis voulait utiliser les embryons congelés dans l'espoir de devenir mère, alors que M. Davis s'y opposait puisqu'il n'avait nullement l'intention d'être père. M^me^ Davis prétendait que ces embryons étaient vivants et qu'elle avait le droit, en tant que mère, de les utiliser pour tenter de concevoir. À défaut de pouvoir les utiliser elle-même, elle prétendait que ces embryons devraient être donnés à un couple infertile pour qu'il les rende à terme. En première instance, le juge W. Dale Young a décidé du litige, le 21 septembre 1989, de la façon suivante (précité, note 207, 1-2) :

> [TRADUCTION]
> Voici un résumé des faits saillants, des conclusions et des motifs de jugement dans cette affaire : (1) M. et M^me^ Davis se sont engagés dans un programme de fécondation visant la conception d'un être humain qui serait leur enfant. (2) Les sept embryons congelés sont des embryons humains. [...] (5) À compter de la fécondation, les cellules de l'embryon humain sont différenciées, uniques et spécialisées au plus haut degré. (6) L'embryon humain n'est pas une chose. (7) La vie humaine commence dès la conception. (8) M. et M^me^ Davis ont conçu in vitro des êtres humains appelés à devenir leurs enfants. (9) Du point de vue des relations familiales, l'intérêt public n'empêche pas l'élaboration de nouvelles règles de common law pour déterminer le sort des sept êtres humains existant, dans cette affaire, sous la forme d'embryons in vitro. (10) La théorie *parens patriae* de common law s'applique à l'enfant in vitro. (11) Il est dans l'intérêt manifeste des enfants in vitro d'être réimplantés. (12) Il est dans l'intérêt véritable des embryons in vitro que leur mère, M^me^ Davis, soit autorisée à mener leur développement à terme grâce à leur implantation.
>
> [...]
>
> La garde temporaire des sept embryons humains congelés est confiée à M^me^ Davis en vue de leur implantation. La Cour réserve sa décision quant aux aliments, aux droits de visite, à la garde permanente et aux questions connexes, qui seront déterminés au moment où l'un ou plusieurs des embryons auront été réimplantés et seront nés vivants.

Pour plus de détails sur cette cause, voir John A. ROBERTSON « Resolving Disputes over Frozen Embryos » (1989), 19:6 *Hast. Cent. Rep.* 7, notamment p. 11 :

> [TRADUCTION]
> La conclusion du juge Young selon laquelle l'embryon pré-implantatoire de quatre cellules est un être humain ou un enfant est sans précédent ni fondement. On ne trouve en effet ni dans la common law, ni dans le droit du Tennessee (où l'existence de droits distincts avant la naissance est conditionnée par la viabilité) le moindre argument pour appuyer cette position qui, du reste, a été écartée par de prestigieux organismes consultatifs en matière d'éthique aux États-Unis, en Grande-Bretagne, au Canada, en France et dans plusieurs autres pays. Cette singulière décision semble avoir été dictée par les sentiments personnels du juge sur l'importance qu'il convient d'attacher au fait biologique de la création d'un nouveau génome dès la fécondation ou peu de temps après.

En appel de l'arrêt *Davis* (précité, note 207, 2206), la Cour conclut :

> [TRADUCTION]
> Dans son interprétation des faits et dans son dispositif, le tribunal de première instance a passé outre à la philosophie qui sous-tend la législation du Tennessee, à la jurisprudence de la Cour suprême du Tennessee et à celle de la Cour suprême des États-Unis. Cette affaire doit être tranchée en conformité avec le droit actuel du Tennessee, dans le respect des droits constitutionnels des parties. D'après les faits, il serait odieux et contraire aux principes constitutionnels de forcer Mary Sue à subir contre son gré l'implantation des embryons. De même, il serait tout aussi odieux de contraindre Junior à assumer contre son gré, la responsabilité morale, sinon juridique, de la paternité. Les parties jouissent de droits conjoints sur les sept oeufs fécondés.
>
> En conséquence, l'affaire est renvoyée au tribunal de première instance pour qu'il confie la garde conjointe des embryons à Mary Sue et à Junior, ceux-ci ayant des droits égaux quant à la façon d'en disposer.

221. Précitée, note 208. La question en litige dans cette cause concernait le droit d'un couple de transférer un embryon congelé d'une clinique de fertilité à une autre. La formule de consentement signée par M. et M^me^ York ne prévoyait pas l'éventualité d'un changement de médecin.

Il faut espérer que l'expérience tirée de ces litiges favorisera la rédaction de formules de consentement plus adéquates. Cela dit, est-il possible de prévoir dans un formulaire le sort d'un embryon en cas de conflit, de séparation, de divorce ou de décès[222] ? Cette question nous amène à nous interroger sur le statut de l'embryon : fait-il partie du domaine des biens ou de celui des personnes ? Le droit positif est inapte à répondre à cette question qui constitue un problème à la fois philosophique, théologique et éthique : celui de l'apparition de la vie humaine[223].

La question de l'autorité sur les gamètes et l'embryon a également été considérée sous l'angle du droit des biens :

> [TRADUCTION]
> Les éléments que sont l'usage, l'aliénation [...] la disposition et la destruction, même lorsque l'exercice de ces facultés est réglementé par la loi, semblent constituer le pouvoir correspondant à la définition juridique du concept de propriété. Et suivant les principes du droit des biens, il semble que le donneur de gamètes puisse exercer ses droits sur l'embryon *ex utero*, les céder à la disposition exclusive de l'autre géniteur (comme dans les cas habituels d'insémination artificielle avec sperme de donneur), consentir à ce qu'un embryon soit réimplanté chez une autre femme sans qu'entre en jeu le droit de l'adoption, et s'appuyer sur le droit des biens pour régler tout litige concernant la façon de disposer des embryons. De la même façon, le donneur de gamètes peut déléguer à une clinique et à son personnel le pouvoir de choisir, par exemple, les femmes à qui seront donnés les embryons surnuméraires[224].

Cependant, la nature du produit « déposé » rend difficile une telle qualification[225]. Certains sont d'avis que ce droit de propriété ne s'entend pas au sens juridique traditionnel

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222. Bernard M. DICKENS, « Artificial Reproduction and Child Custody » (1987), 66 *R. du B. can.* 49, 65 : [TRADUCTION] « La prestation de services d'ordre scientifique ou médical, notamment la cryoconservation et le maintien en vie d'un embryon in vitro, pourrait être prévue dans un contrat sans qu'il soit nécessaire de faire appel aux concepts du droit des biens. »

223. *L'expérimentation biomédicale sur l'être humain*, *op. cit.*, note 7, pp. 50-51. Voir aussi les décisions récentes *Murphy* c. *Dodd* (1989), 70 O.R. (2e) 681 (H.C.J.) ; *Tremblay* c. *Daigle*, C.S. Abitibi, n° 170-05-000012-898, 7 juillet 1988, j. Richard (ordonnance d'injonction interlocutoire provisoire) ; [1989] R.J.Q. 1980 (C.S.) (ordonnance d'injonction interlocutoire) ; [1989] R.J.Q. 1735 (C.A.) (appel rejeté), inf. par un jugement unanime de la Cour suprême du Canada, [1989] 2 R.C.S. 530. Signalons cependant que l'embryon conçu in vitro ne fait pas partie de la définition du fœtus qui figure dans le document de travail *Les crimes contre le fœtus*, *op. cit.*, note 7, p. 52 : « le produit de l'union, dans l'utérus, d'un spermatozoïde et d'un ovule humains, à quelque stade de la vie qui précède l'accession au statut de personne. »

224. B.M. DICKENS, *loc. cit*, note 222, 62-63. L'auteur ajoute aux pp. 64-65 : [TRADUCTION] « La destruction ou autre forme de détournement d'une chose sans le consentement de son propriétaire peuvent constituer le crime de vol et les délits civils d'atteinte à la propriété et d'appropriation illicite. »

225. Bartha M. KNOPPERS, « Reproductive Technology and International Mechanisms of Protection of the Human Person » (1987), 32 *R.D. McGill* 336, 346 :

> [TRADUCTION]
> [T]out le monde s'entend pour dire que l'embryon in vitro est une forme de vie humaine méritant d'être protégée. [...] bien que la majorité des juristes refusent de reconnaître au donneur un

de ce concept, mais qu'il s'agit plutôt d'un « droit de contrôle et de regard[226] ».

Devant cette lacune évidente du droit, plusieurs solutions sont possibles. La première consiste à laisser aux tribunaux le soin d'adapter les principes de droit actuels aux gamètes et aux embryons afin de répondre aux problèmes qu'ils posent. On pourrait d'autre part repenser les catégories traditionnelles du droit, soit celles des choses et des personnes,

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droit de propriété sur les gamètes ou les embryons humains, la plupart lui reconnaissent un droit de possession et, dans certains cas, un droit résiduaire. [...] De fait, il est difficile de songer à un domaine où il serait plus impérieux d'établir à l'échelle internationale des principes de respect et de protection, si nous voulons en venir à distinguer ce qui, dans le matériel génétique humain, constitue un bien, un simple produit de la conception et une forme de vie humaine.

Bernard M. DICKENS, « The Ectogenetic Human Being: A Problem Child of Our Time » (1980), 18 *U.W.O. L. Rev.* 241, 245, [TRADUCTION] « Aux États-Unis, dans les cas où des foetus, auxquels leur mère aurait voulu leur faire des funérailles en bonne et due forme, ont été perdus ou incinérés par l'hôpital, les poursuites ont été engagées au titre d'un préjudice moral et non d'un détournement de bien. » L'auteur fait allusion à *Brooks* c. *South Broward Hospital District*, 325 So. 2d 479 (Fla App. 1975) et *Hembree* c. *Hospital Board of Morgan County*, 300 So. 2d 823 (1974) ; Dans *Del Zio* c. *Manhattan's Columbia Presbyterian Medical Center*, S.D.N.Y., n° 74-3558, 14 novembre 1978, à la suite de la destruction d'un ovule fécondé, un juge de la Cour fédérale américaine a permis qu'une demande en dommages-intérêts pour la perte d'un bien soit entendue par un jury. Toutefois, [TRADUCTION] « [l]e jury a rejeté la réclamation pour perte de bien, mais a accordé aux demandeurs des dommages-intérêts pour préjudice d'ordre affectif, soit 50 000 $ à M^me^ Del Zio et 3 $ à M. Del Zio. » Lori B. ANDREWS, « My Body, My Property » (1986), 16:5 *Hast. Cent. Rep.* 28, 29 et suiv.

226. Selon J.-L. BAUDOUIN et C. LABRUSSE-RIOU, *op. cit.*, note 214, pp. 45-46 :

> [O]n doit reconnaître au donneur non pas un véritable droit de propriété mais plus un droit de contrôle et de regard sur l'utilisation de ses gamètes, élément de l'ensemble plus vaste des droits de la personnalité. Par contre, pour des raisons sociales évidentes, ce droit ne doit pas pouvoir s'exercer à la façon d'un droit de propriété véritable. [...] C'est donc, *de lege ferenda*, un équilibre qu'il faut trouver entre le respect du consentement et des intentions du donneur, d'une part, et, d'autre part, un exercice de ce droit de contrôle compatible avec les exigences éthiques et sociales de l'ensemble du groupe social.

Le terme « donneur » semble être ici utilisé tant pour désigner la personne qui fait un dépôt que la personne qui fait un don réel, c'est-à-dire qui aliène le produit de son don ; *ibid.* : « On imagine mal, par exemple, le *donneur* léguant une fortune considérable à sa petite-fille à la condition qu'elle se fasse inséminer, après sa mort, avec le sperme qu'il a *déposé* dans une banque à cette intention ! » [Mis en italiques par nos soins]. La Commission de réforme du droit de l'Ontario mentionne ce qui suit :

> [TRADUCTION]
> On a laissé entendre que le fait qu'une personne n'ait pas la « propriété » absolue à titre bénéficiaire d'une chose ne signifie pas qu'elle n'a aucun droit de « propriété » ou autre (de possession, par exemple) sur cette chose. [Note 224 : Ainsi, dans certaines circonstances, la *Loi sur l'anatomie*, L.R.O. 1980, ch. 21, permet aux facultés de médecine d'avoir la possession de cadavres aux fins de dissection et d'enseignement médical, encore que l'on ait affirmé qu'un cadavre ne pouvait faire l'objet d'un droit de propriété.] Par conséquent, même si les droits d'une femme à l'égard de ses ovules sont assujettis à des restrictions, sans doute doit-on leur reconnaître une certaine portée. En outre, il va sans dire que le droit d'une personne sur un matériel génétique, quelles qu'en soient les modalités, peut permettre à cette personne, par exemple, de donner ce matériel à un hôpital à des fins expérimentales ou d'exiger qu'il soit détruit à l'encontre de la volonté de ceux qui en revendiqueraient l'utilisation aux mêmes fins : son droit pourrait prévaloir sur celui de quiconque.

CRDO, *op. cit.*, note 2, p. 88.

afin de tenir compte des particularités de ces substances corporelles[227]. Enfin, il pourrait être opportun d'étudier la possibilité d'adapter la notion de choses hors du commerce à ces substances[228]. La portée de cette alternative ne se limite pas au problème de l'autorité sur ces substances ; elle vise aussi la légitimité même du don de gamètes et d'embryon, et la question de la commercialisation de ceux-ci. Nous reviendrons sur ces questions plus loin.

3. L'utilisation posthume des gamètes et des embryons

La question de l'utilisation posthume des gamètes ou des embryons nous ramène aux questions du droit d'en disposer et de leur statut juridique[229]. Une veuve ou un veuf a-t-il des droits sur les gamètes de son conjoint décédé ou sur les embryons qu'ils ont conçus ensemble ?

Comme nous l'avons vu dans l'affaire *Parpalaix*[230], les tribunaux français ont qualifié le dépôt de sperme de contrat spécifique et autorisé la remise du sperme à la veuve du défunt, permettant ainsi l'insémination posthume. Mais c'est une approche très formaliste du litige qui a mené à une telle conclusion puisque, en l'espèce, le juge ne s'est pas prononcé sur l'utilisation du sperme aux fins d'insémination posthume.

Sur un plan plus pratique, il est facile d'entrevoir les sérieux problèmes que pourrait entraîner l'utilisation posthume de gamètes et d'embryons pour le droit de la filiation et le droit des successions[231]. Le droit canadien, tant du point de vue des successions que de celui de la filiation, ne connaît pas la procréation posthume. La présomption de paternité repose habituellement sur un critère de trois cents jours entre le décès du père et la naissance de l'enfant[232]. La législation ontarienne prévoit que, dans le cas où personne n'est présumé être le père au regard du critère susmentionné, toute personne peut présenter une requête en déclaration de paternité[233], si « les deux personnes dont on cherche à établir la filiation sont vivantes[234]. »

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227. Voir, à ce sujet, M.-A. HERMITTE, *loc. cit.*, note 211.

228. Voir, à ce sujet, J.-C. GALLOUX, *loc. cit.*, note 212.

229. Voir *supra*, pp. 46, 50.

230. Précitée, note 206.

231. À titre d'exemple, voir l'affaire *Rios*, précitée, note 208.

232. À titre d'exemple, voir la *Loi portant réforme du droit de l'enfance*, L.R.O. 1980, ch. 68, al. 8(1) 2°, qui présume la paternité d'une personne si : « [e]lle était unie à la mère de l'enfant par les liens d'un mariage qui a été dissous [...] par un décès [...] dans les 300 jours qui ont précédé la naissance de l'enfant ». Au Québec, l'art. 574 C.c.Q. prévoit que l'enfant né plus de trois cents jours après la mort de son père biologique est réputé conçu après le décès de celui-ci ; voir également l'art. 523 du projet de loi 125, précité, note 200.

233. Voir la *Loi portant réforme du droit de l'enfance*, précitée, note 232, par. 5(1).

234. *Id.*, par. 5(2). B.M. DICKENS, *loc. cit.*, note 225, 247 : [TRADUCTION] « Seraient donc exclus le père biologique décédé et l'enfant non encore né. Il semble que le fœtus ne puisse être considéré comme lié

Nous pouvons donc nous interroger sur l'opportunité, pour notre droit, de prévoir les conséquences de la conception d'un enfant posthume en matière de filiation et de successions. Mais, auparavant, nous devons décider s'il convient d'accepter ou d'interdire l'utilisation posthume de gamètes et d'embryons dans notre société.

B. Le donneur

1. Légalité, légitimité et nature du don de gamètes et d'embryon[235]

La légalité du don de gamètes ou d'embryon ressortit au principe de l'inviolabilité du corps humain[236].

> [L]e principe de l'inviolabilité peut être interprété de deux façons différentes. Il peut d'une part signifier que nul ne peut être traité sans son consentement, ce qui revient tout simplement à appliquer le principe de l'autonomie. D'autre part, il peut s'interpréter comme une application du principe de la conservation de la vie lorsqu'il s'agit de préserver l'intégrité physique et mentale de la personne contre des actes néfastes, de son fait ou du fait d'autrui[237].

Cette seconde interprétation du principe de l'inviolabilité du corps humain a pour effet de restreindre ce à quoi l'on peut consentir. C'est la position que semble avoir retenue le législateur québécois lorsqu'il a modifié le Code civil en 1971[238].

L'article 20 C.c. permet à toute personne capable d'aliéner une partie de son corps, que celle-ci soit de nature à se régénérer ou non, sous réserve de la proportionnalité du risque et du consentement écrit dans les deux cas. Voici le libellé de cette disposition :

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au père pour l'application de la règle interdisant les dispositions à titre perpétuel et les autres droits de propriété. » Signalons toutefois que la loi uniforme sur le statut de l'enfant (précitée, note 203) prévoit une exception à cette règle lorsque la présomption de paternité prévue à l'art. 9 s'applique. Or la présomption de paternité prévue en cas de décès du père de l'enfant n'indique aucune limite de temps pour la naissance de l'enfant ou le décès du mari. Voir le par. 6(6) et l'al. 9*a*).

235. La légalité s'entend ici de la conformité d'un acte ou d'une entreprise au droit alors que la légitimité vise les critères éthiques et sociaux qui rendent souhaitable soit l'interdiction, soit la permission, soit la simple tolérance de cet acte ou de cette entreprise.

236. Au Québec, c'est l'art. 19 C.c. qui consacre ce principe : « La personne humaine est inviolable. Nul ne peut porter atteinte à la personne d'autrui sans son consentement ou sans y être autorisé par la loi. » Voir également les art. 19.1 à 19.4 C.c. et l'art. 10 et suiv. du projet de loi 125, précité, note 200.

237. Margaret A. Somerville, *Le consentement à l'acte médical*, document d'étude préparé pour la CRD, Ottawa, Approvisionnements et Services Canada, 1980, pp. 5-6.

238. Voir en ce sens François Heleine, « Le dogme de l'intangibilité du corps humain et ses atteintes normalisées dans le droit des obligations du Québec contemporain » (1976), 36 *R. du B.* 2, 10.

Le majeur peut consentir par écrit à l'aliénation entre vifs d'une partie de son corps ou à se soumettre à une expérimentation, pourvu que le risque couru ne soit pas hors de proportion avec le bienfait qu'on peut en espérer.

Le mineur doué de discernement le peut également avec l'autorisation d'un juge de la Cour supérieure et le consentement du titulaire de l'autorité parentale à condition qu'il n'en résulte pas un risque sérieux pour sa santé.

L'aliénation doit être gratuite à moins que son objet ne soit une partie du corps susceptible de régénération.

Le consentement doit être donné par écrit ; il peut être pareillement révoqué.

Dans la mesure où les conditions énumérées à l'article 20 sont respectées, et à supposer que les gamètes soient considérés comme des parties du corps au sens de cet article, la légalité du don de gamètes ne fait pas de doute en droit québécois[239].

Quant aux provinces de common law, elles disposent de lois sur le don de tissus humains inspirées de la loi uniforme sur le don de tissus humains[240], dont le paragraphe 3(1) est rédigé comme suit :

[TRADUCTION]
Toute personne majeure, capable et apte à décider librement et en connaissance de cause peut consentir, dans un écrit signé de sa main, à ce que le tissu désigné dans le consentement soit immédiatement prélevé de son corps pour être implanté dans celui d'une autre personne vivante[241].

Même si la loi uniforme sur le don de tissus humains ne mentionne pas que le risque couru ne doit pas être disproportionné au bienfait espéré, cette condition est reconnue par

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239. Voir J.-L. BAUDOUIN et C. LABRUSSE-RIOU, *op. cit.*, note 214, p. 44. Signalons que les art. 18-22 de la *Loi portant réforme au Code civil du Québec du droit des personnes, des successions et des biens*, L.Q. 1987, ch. 18, reprennent en substance l'art. 20 et suiv. C.c. et y ajoutent des précisions et exigences particulières. Voir Monique OUELLETTE, « De la jouissance et de l'existence des droits civils et de certains droits de la personnalité » (1988), 1 *C.P. du N.* 1, 20. Voir également les art. 19 à 25 du projet de loi 125, précité, note 200.

240. *Uniform Human Tissue Gift Act* (ci-après loi uniforme sur le don de tissus humains, 1971), abrogé et remplacé par la *Loi uniforme sur le don de tissus humains*, 1989, CONFÉRENCE SUR L'UNIFORMISATION DES LOIS AU CANADA, *op. cit.*, note 203, p. 22-9. Voici la liste des lois canadiennes en la matière : *Human Tissue Gift Act*, R.S.A. 1980, ch. H-12 ; *Human Tissue Gift Act*, R.S.B.C. 1979, ch. 187 ; *Loi sur les tissus humains*, L.M. 1987-88, ch. 39 ; *The Human Tissue Act, 1971*, S.N. 1971, n° 66 ; *Loi sur les tissus humains*, L.R.N.-B. 1973, ch. H-12 ; *Human Tissue Gift Act*, R.S.N.S. 1989, ch. 215 ; *Loi sur le don de tissus humains*, L.R.O. 1980, ch. 210 ; *Human Tissue Gift Act*, R.S.P.E.I. 1988, ch. H-13 ; *The Human Tissue Gift Act*, R.S.S. 1978, ch. H-15 ; *Loi sur les tissus humains*, L.R.T.N.-O. 1988, ch. H-6 ; *Human Tissue Gift Act*, R.S.Y.T. 1986, ch. 89 ; voir plus précisément, à titre d'exemple, la loi ontarienne, al. 1*c*) et la loi albertaine, al. 1*b*).

241. Précitée, note 240. L'alinéa 1*c*) définit le terme « tissu » de la façon suivante : [TRADUCTION] « Est assimilé à un tissu tout organe, mais sont exclus la peau, les os, le sang et ses composants, de même que tout tissu susceptible de se régénérer naturellement. »

la common law[242]. Cependant, à la différence du Code civil, la loi uniforme exclut les tissus susceptibles de régénération[243].

Dans la mesure où le sperme et même les ovocytes (malgré le fait que ces derniers sont limités en nombre) sont des parties du corps susceptibles de régénération[244], les dispositions des lois sur le don de tissus humains ne s'appliquent pas et c'est la common law qui régit le don de gamètes : [TRADUCTION] « En common law, l'adulte peut, en pleine connaissance de cause, consentir à ce que des tissus susceptibles de régénération soient prélevés sur son corps. Et de fait, le Service des transfusions sanguines de la Croix-Rouge est entièrement tributaire de ces prélèvements[245]. »

Si nous pouvons conclure (sous réserve de l'ambiguïté qui entoure la qualification des gamètes) que nos systèmes juridiques ne laissent planer aucun doute sur la légalité du don de gamètes, la légitimité du don, elle, porte à controverse en raison de la nature même des gamètes.

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242. Voir B.M. KNOPPERS, *op. cit.*, note 200, pp. 95-96, n. 149. Voir aussi Bernard M. DICKENS, « The Control of Living Body Materials » (1977), 27 *U.T.L.J.* 142, 165, [TRADUCTION] « La démarcation entre ce qui est permis et ce qui est prohibé en matière d'aliénation de tissus relève de l'intérêt public, tel qu'il est exprimé par les tribunaux. Or l'intérêt public évolue avec le temps et peut être adapté aux progrès biotechniques, aux fluctuations des priorités sociales et à la reconnaissance des limites de l'altruisme. » Voir également, de façon générale, E.I. PICARD, *op. cit.*, note 200, p. 67 et suiv., p. 125 et suiv. ; *Hopp* c. *Lepp*, [1980] 2 R.C.S. 192 ; *Reibl* c. *Hughes* (1977), 16 O.R. (2e) 306 (H.C.J.), infirmé par (1978) 21 O.R. (2e) 14 (C.A.), infirmé par [1980] 2 R.C.S. 880. Par ailleurs, en droit criminel, l'art. 45 du *Code criminel*, L.R.C. (1985), ch. C-46, prévoit ce qui suit :

> Toute personne est à l'abri de responsabilité pénale lorsqu'elle pratique sur une autre, pour le bien de cette dernière, une opération chirurgicale si, à la fois :
>
> *a*) l'opération est pratiquée avec des soins et une habileté raisonnables ;
>
> *b*) il est raisonnable de pratiquer l'opération, étant donné l'état de santé de la personne au moment de l'opération et toutes les autres circonstances de l'espèce.

Voir aussi l'art. 14 du *Code criminel*.

243. Loi uniforme sur le don de tissus humains, 1971, précitée, note 240. La plus récente version de cette loi, la nouvelle *Loi uniforme sur le don de tissus humains*, 1989, offerte aux provinces pour adoption, définit le terme « tissu » à l'art. 1 : « toute partie du corps humain, vivant ou mort, à l'exception *a*) des spermatozoïdes et des ovules, *b*) des embryons et des foetus, [...] » Reste à savoir si les provinces donneront suite à ces modifications.

244. Voir B.M. KNOPPERS, *op. cit.*, note 200, p. 109 ; F. HELEINE, *loc. cit.*, note 238, 61, « [E]n l'état actuel de la connaissance médicale, sont considérées parties susceptibles de régénération, le sang, le lait, le cheveu, la peau, la moelle osseuse et le matériel génétique ». Commentant la loi ontarienne (précitée, note 240), la CRDO écrit dans son rapport, *op. cit.*, note 2, p. 60 :

> [TRADUCTION]
>
> La question fondamentale est évidemment celle de savoir si la loi s'applique au don de sperme ou d'ovule, c'est-à-dire si le sperme et l'ovule sont visés par la définition légale du terme tissu. L'alinéa 1*c*) de la loi prévoit que le terme s'entend notamment d'un organe, mais non de la peau, des os, du sang, des dérivés du sang, ni d'aucun autre tissu susceptible de régénération. [...]
>
> Il semble ne faire aucun doute que le sperme est visé par le dernier membre de phrase de l'alinéa 1*c*), ce qui le soustrait à l'application du paragraphe 3(1). On ne saurait toutefois en dire autant de l'ovule. Chez la femme, en effet, le stock ovarien est limité et s'épuise de mois en mois, au cours des menstruations, de la puberté à la ménopause.

245. E.I. PICARD, *op. cit.*, note 200, p. 129. Voir aussi B.M. DICKENS, *loc. cit.*, note 242, 163-164.

Pour certains auteurs, les discussions au sujet du don de gamètes et d'embryon sont trop souvent centrées sur sa réglementation et les conditions dont il peut être assorti et ce, au détriment de la question de sa valeur éthique :

> Certaines interrogations essentielles, touchant le don de gamètes, ont été ainsi purement et simplement médicalisées et donc banalisées. La science a habitué à une perception que les difficultés ne se situent pas dans la valeur éthique de l'opération elle-même, mais, celle-ci étant assurée, dans les contrôles et les conditions qui peuvent y être imposés. De ce fait, le public et les juristes ont été conditionnés à penser que la légitimité, et par conséquent la légalité du don de gamètes, n'était plus ouverte à un questionnement éthico-juridique. Restait dès lors à s'adresser au droit pour obtenir de lui des modèles processuels de gestion. En focalisant les débats sur le « comment », on a ainsi véritablement oublié le « pourquoi ». La science a agi comme si les seules véritables difficultés étaient de nature technique[246].

Avant de clore le débat sur la légitimité du don de gamètes, il faudrait donc, selon certains, procéder à une analyse éthique et juridique des questions fondamentales que soulève le don de gamètes pour notre société. Marie-Angèle Hermitte résume cette démarche de la façon suivante :

> Il faut savoir si l'on veut être une société qui met la parenté dans l'échange, ou non [...] Pour répondre à la question, il faudra déterminer si on analyse cet échange comme un simple don de vie ou comme un déplacement de l'ordre des parentèles. Dans le premier cas, on fait une analyse matérialiste, purement biologique où l'IAD [insémination artificielle avec sperme de donneur] apparaît comme une thérapeutique un peu magique à la stérilité. Dans l'autre cas le don de vie est inclus dans la logique d'une généalogie, et l'on prend conscience que l'on rompt une branche de l'arbre généalogique. C'est au fond toujours le même problème : les corps ne sont-ils que de la matière vivante, qui peut circuler selon les règles de l'échange ; ne sont-ils pas aussi le support de représentations culturelles qui les transcendent, en partie tout au moins[247].

Après cette analyse sommaire du don de gamètes, nous devons maintenant aborder le don d'embryon. Le don d'embryon n'est prévu ni par le droit civil ni par la common law. L'embryon peut en effet difficilement être qualifié de tissu ou de partie du corps (susceptible ou non de régénération). L'ambiguïté de sa qualification est la source d'objections d'ordre moral et social qui ont fait leur apparition avec la création d'embryons surnuméraires et leur congélation. C'est la représentation que l'on se fait de l'embryon (chose, personne, personne potentielle, etc.) qui est ici en question. La question de la légitimité du don d'embryon reste donc entière. Voulons-nous légaliser le don d'embryon ou voulons-nous au contraire l'interdire ?

Pour terminer cette discussion sur la légalité et la légitimité du don de gamètes et d'embryon, nous pouvons nous demander, de façon plus générale, si nous voulons traiter

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246. J.-L. Baudouin et C. Labrusse-Riou, *op. cit.*, note 214, p. 195.

247. *Loc. cit.*, note 211, 337.

les gamètes et les embryons d'une façon différente des autres parties du corps ou des cellules aliénables, c'est-à-dire créer un régime particulier adapté à leur nature[248].

Il convient en dernier lieu d'aborder la question de la nature même du don de gamètes ou d'embryon. S'agit-il d'un don aveugle ou le donneur peut-il l'assortir de conditions ? Est-il en droit de revenir sur sa décision ?

Si le don de tissus ou de substances corporelles comme le sang, le lait ou la moelle osseuse pose peu de problèmes moraux, le don de gamètes ou d'embryon, c'est-à-dire le don d'une vie humaine potentielle, est plus délicat. Le donneur peut en effet, vu l'importance d'un tel don, vouloir y attacher certaines conditions d'utilisation. C'est pourquoi le don de gamètes et d'embryon devrait être conditionné par le consentement libre et éclairé du donneur, non seulement quant à la technique utilisée et aux risques courus, mais aussi quant à la finalité du don. Et pour cela, il est essentiel que le donneur soit mis au courant de la façon dont le produit de son don sera utilisé.

En common law, il semble bien que le don d'organes et de tissus qui ne se régénèrent pas puisse être assorti de conditions[249]. À plus forte raison, le don de gamètes ou d'embryon devrait pouvoir faire l'objet de conditions pourvu que celles-ci ne soient pas discriminatoires[250].

Quant au droit du donneur de retirer son consentement au don, il est prévu, en droit civil québécois, à l'article 20 C.c.[251]. En common law, l'existence de ce droit dépend de la nature du contrat. Si le contrat est qualifié de louage de services, il serait possible au donneur de retirer son consentement en tout temps. Par contre, s'il s'agit de la vente d'un bien, il serait privé de cette faculté[252]. Or, on peut se demander s'il est souhaitable

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248. Dans son document de travail sur l'expérimentation, la CRD écrit : « Les gamètes et les embryons humains ne peuvent être considérés ni comme de simples cellules, ni comme de simples tissus. Les premiers sont les sources virtuelles de nouvelles vies humaines ; les seconds possèdent déjà la vie. » Voir *L'expérimentation biomédicale sur l'être humain*, *op. cit.*, note 7, p. 59.

249. Loi uniforme sur le don de tissus humains, 1971, précitée, note 240, par. 3(4) : [TRADUCTION] « Le consentement est nul si, pour une raison quelconque, le tissu visé n'est pas prélevé dans les conditions prévues » ; art. 8 : [TRADUCTION] « Si, pour une raison quelconque, un don fait conformément à la présente partie ne peut être utilisé à aucune des fins précisées dans le consentement, il est disposé de l'objet de ce don et du corps auquel il appartient comme si le consentement n'avait pas été donné ». Voir aussi à titre d'exemple la loi albertaine sur le sujet, précitée, note 240, par. 3(4) et art. 8.

250. Voir en ce sens J.-L. BAUDOUIN et C. LABRUSSE-RIOU, *op. cit.*, note 214, p. 45 : « Le don de sperme n'est [...] pas un don "aveugle", mais un don orienté et dirigé, un don conditionnel, faisant partie d'un véritable pacte entre le donneur d'un côté, le médecin d'un autre côté et, à travers lui, le ou les bénéficiaires. Donner la potentialité d'une vie humaine n'est pas un acte éthiquement neutre et doit donc être évalué et respecté comme tel. »

251. Voir *supra*, pp. 53-54. La *Loi portant réforme au Code civil du Québec du droit des personnes, des successions et des biens*, précitée, note 239, art. 21, prévoit la révocation même verbale du consentement. L'article 24 du projet de loi 125, précité, note 200, est au même effet.

252. CRDO, *op. cit.*, note 2, p. 62.

d'assujettir la révocabilité du consentement à la nature du contrat de don (vente de bien ou louage de services). La nature du produit donné et l'importance du don de vie ne sont-elles pas des raisons suffisantes pour justifier la révocabilité du don de gamètes et d'embryon ?

2. Gratuité et anonymat du don de gamètes et d'embryon

En vertu du droit actuellement en vigueur dans les provinces de common law, la vente de tissus et de parties du corps humain est généralement prohibée par des dispositions législatives qui la tiennent pour contraire à l'ordre public :

> [TRADUCTION]
> Nul ne doit, directement ou indirectement, acheter ou vendre un tissu destiné à une transplantation, ou un corps ou l'une de ses parties, à l'exception du sang et ses composants, ou en faire le commerce de quelque autre façon, à des fins thérapeutiques, pour l'enseignement de la médecine ou pour la recherche scientifique. Toute opération de cette nature est nulle et contraire à l'ordre public[253].

L'étendue de cette prohibition n'est cependant pas tout à fait claire. Ainsi, la définition du terme « tissu » exclut les tissus qui sont de nature à se régénérer, ce qui porte à croire que ces derniers ne sont pas visés par la prohibition. Pourtant, les termes utilisés dans la disposition semblent bien indiquer l'intention d'y inclure également la vente de tissus susceptibles de se régénérer : « nul ne doit [. . .] acheter ou vendre [. . .] *un tissu destiné à une transplantation*, ou un corps ou l'une de ses parties, *à l'exception du sang et ses composants* [. . .][254] » [mis en italiques par nos soins].

Au Québec, l'article 20 C.c. permet la vente des parties du corps qui se régénèrent[255]. Par conséquent, si les gamètes sont considérés comme des tissus ou des parties du corps susceptibles de se régénérer, la gratuité du don ne serait pas essentielle.

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253. La loi uniforme sur le don de tissus humains, 1971, précitée, note 240, art. 10. Rappelons que les provinces de common law ont repris, pour la plupart, le même modèle. Cet article a été modifié par les dispositions suivantes, où n'apparaît plus la notion d'ordre public (*Loi uniforme sur le don de tissus humains*, 1989, précitée, note 240) :

> 15. (1) Nul ne peut acheter ou vendre, directement ou indirectement, un tissu, un corps ou une partie de corps humain, ou en faire le commerce à des fins de transplantation, d'enseignement médical, de recherche scientifique ou à des fins thérapeutiques.
>
> (2) Tout commerce de corps ou de partie de corps humain autorisé par la loi avant que la présente loi n'entre en vigueur continuera de l'être, sauf disposition contraire contenue dans la présente loi.
>
> (3) La personne qui contrevient aux dispositions du présent article commet une infraction et se rend passible, sur déclaration sommaire de culpabilité, d'une amende d'au plus 100 000 $ ou d'un emprisonnement d'au plus un an, ou de ces deux peines concurremment.

Comme nous l'avons vu (*supra*, note 241), la définition de « tissu » dans la nouvelle loi uniforme exclut les spermatozoïdes, les ovules, les embryons et les fœtus.

254. *Ibid.* Pour plus de détails à ce sujet, voir le document de travail de la CRD, *Prélèvement et utilisation médicale de tissus et d'organes humains* (à paraître).

255. L'article 22 de la *Loi portant réforme au Code civil du Québec du droit des personnes, des successions et des biens*, précitée, note 239, prévoit ce qui suit : « L'aliénation d'une partie du corps humain non susceptible

La nature des gamètes nous amène néanmoins à nous interroger sur l'opportunité de soustraire ceux-ci à toute forme de commercialisation, de ne permettre que le remboursement des frais[256] et de limiter la circulation et la conservation des gamètes aux hôpitaux et cliniques d'infertilité sans but lucratif. Dans la même optique, il nous faut également songer à réglementer l'importation d'ovocytes et de sperme. Par ailleurs, le don d'embryon soulève des questions analogues.

Autre caractéristique propre au don de gamètes et d'embryon : il se fait généralement sous la condition, tacite ou explicite, de l'anonymat du donneur. Il faut donc s'assurer que ce dernier est adéquatement protégé contre la divulgation de son identité.

À supposer que le donneur puisse être considéré comme un « patient », il est protégé, tant en droit civil qu'en common law, par les règles de la confidentialité qui entourent normalement toute communication entre le patient et son médecin. Ce dernier a toujours été tenu, aussi bien en vertu de l'éthique médicale que par la loi, de ne pas divulguer les renseignements médicaux contenus dans le dossier de ses patients[257] : [TRADUCTION] « Il est bien établi en droit que le médecin est tenu à une obligation de confidentialité envers son patient. Cette obligation est reconnue en common law, elle a reçu la sanction du législateur dans au moins deux provinces et il n'est pas improbable qu'elle fasse l'objet d'une garantie constitutionnelle[258]. »

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de régénération (sic) doit être gratuite. » A contrario, la vente d'une partie du corps susceptible de régénération est donc possible. Voir M. OUELLETTE, *loc. cit.*, note 239, 21-22. Toutefois, l'al. 2 du même article, de droit nouveau, prévient l'exploitation en édictant l'interdiction suivante : « L'aliénation d'une partie du corps ne peut être répétée si elle présente un risque pour la santé. » Cependant, l'art. 25 du projet de loi 125, précité, note 200, ne fait plus cette distinction pour les parties du corps susceptibles de régénération. Voir *supra*, note 214.

256. La loi modifiant la loi uniforme sur le statut de l'enfant, précitée, note 203, prévoit ce qui suit à l'art. 11.5 :

> [TRADUCTION]
> (1) Il est interdit d'acheter ou de vendre des ovules, du sperme ou des embryons humains, ou d'en faire le commerce de quelque autre façon.
>
> (2) Quiconque contrevient au présent article est coupable d'une infraction et encourt, sur déclaration de culpabilité par procédure sommaire, une amende maximale de 100 000 $ et un emprisonnement maximal d'un an, ou l'une de ces peines.
>
> (3) Le présent article n'a pas pour effet d'interdire le remboursement des frais raisonnablement engagés par une personne pour le don de ses propres ovules ou de son propre sperme.

257. La règle 6 du *Code de déontologie* de l'ASSOCIATION MÉDICALE CANADIENNE, Ottawa, l'Association, 1990, se lit ainsi : « Pour se conformer à la déontologie médicale, le médecin doit : [...] 6. respecter les confidences reçues de ses malades ou collègues et ne divulguer ces renseignements qu'avec la permission du malade, sauf lorsque la loi l'y oblige ».

258. Donald G. CASSWELL, « Disclosure by a Physician of AIDS-Related Patient Information: An Ethical and Legal Dilemma » (1989), 68 *R. du B. can.* 225, 228, n. 12 ; en common law, l'auteur fait référence aux décisions suivantes : *A.B.* c. *C.D.* (1851), 14 Dunlop's S.C. 177 (C. Sess. Scot.) ; *Furniss* c. *Fitchett*,

Les deux systèmes juridiques partagent également une règle selon laquelle l'information ne peut être divulguée que si le patient y consent, ou encore lorsque la divulgation est exigée par la loi[259] ou par l'intérêt public[260].

Il est également possible que des renseignements confidentiels soient révélés devant un tribunal. Ce risque semble cependant plus grand en common law puisque le médecin ne jouit d'aucun privilège en tant que témoin[261], alors que, en droit civil, le médecin devra garder le secret devant le tribunal, à moins que le patient ne le relève de son obligation[262].

Étant donné la situation particulière du donneur[263], nous pouvons nous demander s'il convient de lui appliquer le même régime juridique qu'au patient. D'autre part, le don de gamètes ou d'embryon pouvant difficilement être dissocié du contexte bien particulier de la procréation médicalement assistée, nous ne pouvons pas ne pas tenir compte du besoin d'information des autres intéressés[264]. Dans ces conditions, il y aurait lieu d'envisager la mise sur pied d'un autre système de protection qui garantirait à la fois la protection de la vie privée du donneur et l'accès des autres intéressés à l'information nécessaire (médicale, génétique et sociale).

3. Le consentement du donneur

Comme nous l'avons vu[265], le principe de l'inviolabilité du corps humain assujettit le don de sperme, d'ovule ou d'embryon au consentement libre et éclairé du donneur. Au Québec, l'article 20 C.c. précise que ce consentement doit être donné par écrit. Il en va de même dans les autres provinces canadiennes qui ont repris l'article 3 de la loi

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[1958] 77 N.Z.L.R. 396, 400 (C.S.) ; *Halls* c. *Mitchell*, [1928] R.C.S. 125, 136 ; *Re Inquiry into Confidentiality of Health Records in Ontario* (1979), 24 O.R. (2e) 545 (C.A.), inf. par *sub nom. : Solliciteur général du Canada* c. *Commission royale d'enquête sur la confidentialité des dossiers de santé en Ontario*, [1981] 2 R.C.S. 494, 500-501. Au Québec, l'auteur renvoie à la *Charte des droits et libertés de la personne*, L.R.Q., ch. C-12, art. 5, 9, à la *Loi médicale*, L.R.Q., ch. M-9, art. 42 et au *Code de déontologie des médecins*, R.R.Q. 1981, ch. M-9, r. 4, art. 3.01.

259. E.I. Picard, *op. cit.*, note 200, pp. 17-19 ; Gilbert Sharpe, *The Law and Medicine in Canada*, 2e éd., Toronto, Butterworths, 1987, pp. 184-191.

260. D.G. Casswell, *loc. cit.*, note 258, 231.

261. B.M. Knoppers, *op. cit.*, note 200, p. 125 ; voir aussi *Halls* c. *Mitchell*, précité, note 258, 136.

262. Voir la *Loi médicale*, précitée, note 258, art. 42, et l'art. 9 de la Charte québécoise, précitée, note 258.

263. Il existe une incertitude, tant au Québec que dans les provinces de common law, au sujet de l'assimilation du donneur au patient. Voir le rapport de la CRDO, *op. cit.*, note 2, p. 83, et Bartha Maria Knoppers, « Vérité et information de la personne » (1987), 18 *R.G.D.* 819, 830.

264. Voir *infra*, p. 168 et suiv.

265. Voir *supra*, p. 53 et suiv.

uniforme sur le don de tissus humains de 1971[266]. De plus, tant en droit civil qu'en common law, le risque couru ne doit pas être hors de proportion avec le bienfait qu'on peut en espérer.

Le don d'ovule pose toutefois un problème particulier. En effet, dans le cas où une femme aurait consenti à une intervention comportant le prélèvement d'ovocytes (pour quelque raison que ce soit), il n'est pas certain, dans l'état actuel du droit, qu'il soit nécessaire de requérir son consentement pour pouvoir disposer des ovocytes recueillis si elle n'en a pas elle-même précisé la destination :

> [TRADUCTION]
> Des ovocytes pourront être prélevés [. . .] par exemple lorsque l'on procède, chez une femme, à une stérilisation, à l'exploration de l'hypofertilité ou à une hystérectomie. En outre, lorsque l'on a recours à la stimulation ovarienne pour permettre à la femme de tomber enceinte dans le cadre d'un programme de fécondation in vitro, les ovocytes surnuméraires pourront être mis à la disposition d'autres intéressés [. . .] Il n'est pas certain que la femme sur laquelle sont prélevés les ovocytes soit, en droit, tenue de consentir à ce que ceux-ci soient utilisés aux fins de fécondation in vitro ou de don à d'autres femmes. En revanche, si elle manifeste l'intention de garder les ovocytes à sa disposition, sa volonté doit être respectée[267].

Malgré l'existence d'un consentement plus général, la nature particulière des ovocytes et l'importance de ce don pour la femme devraient justifier la nécessité d'un consentement spécifique.

Le consentement au don d'embryon soulève pour sa part d'autres difficultés. En effet, que l'embryon soit issu des gamètes des deux conjoints ou qu'il ait été conçu au moyen

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266. Précitée, note 240. Il est à noter cependant que la nouvelle version de cette loi, offerte comme modèle aux provinces, n'exige pas de consentement écrit : voir *Loi uniforme sur le don de tissus humains*, 1989, par. 5(1).

267. Bernard M. DICKENS, « Reproduction Law and Medical Consent » (1985), 35 *U.T.L.J.* 255, 283, mentionne l'affaire *Venner* c. *Maryland*, 354 A. 2d 483, 499 (1976), où l'on a décidé ce qui suit : [TRADUCTION] « [L]orsqu'une personne ne dit ni ne fait rien pour manifester son intention d'exercer son droit à la propriété, à la possession ou à la disposition de ses gamètes, la seule conclusion logique que l'on puisse en tirer, c'est qu'elle a choisi d'y renoncer. »

Voir aussi CRDO, *op. cit.*, note 2, p. 89 :

> [TRADUCTION]
> À supposer que le droit à la propriété ou à la possession des gamètes appartienne au géniteur — et, par conséquent, qu'il ne soit pas automatiquement transféré à l'hôpital ou au médecin qui conserve les gamètes ou les utilise pour ses travaux —, il subsiste certaines questions quant à savoir, notamment, si ces droits peuvent être perdus par le défaut de les exercer ou si, en l'absence de directives explicites, le géniteur des ovocytes ou des spermatozoïdes peut à bon droit présumer que l'hôpital et le médecin ont l'obligation légale de détruire les gamètes non utilisés et ne sont pas habilités à procéder à quelque expérimentation, si ce n'est l'examen de routine d'un pathologiste.

des gamètes d'un seul des conjoints et d'un donneur, de qui doit venir le consentement[268] ? Enfin, comme nous l'avons vu[269], la nature révocable du consentement au don suscite certaines questions pour les provinces de common law.

4. La responsabilité du donneur

La divulgation d'information trompeuse ou la non-divulgation de certains renseignements de la part du donneur au sujet de ses antécédents médicaux peut être dommageable à l'enfant et à la mère. Si, par exemple, le donneur cache le fait qu'il est porteur d'une maladie génétiquement transmissible, et que l'enfant né de ses gamètes en soit atteint, il pourrait engager sa responsabilité ; il aurait donc une obligation de divulgation.

Mais qui pourrait le poursuivre en justice ? En droit civil, « l'enfant conçu mais non encore né bénéficie, du moins conditionnellement à sa naissance, d'une certaine reconnaissance juridique[270]. » En common law, les parents et l'enfant bénéficient d'un recours en responsabilité civile délictuelle (*wrongful birth*)[271].

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268. B.M. KNOPPERS, *op. cit.*, note 200, pp. 99-100.

269. Voir *supra*, pp. 57-58.

270. J.-L. BAUDOUIN et C. LABRUSSE-RIOU, *op. cit.*, note 214, p. 57 ; Michèle RIVET, « Le droit à la vie ou "l'hominisation" du XXI[e] siècle : l'éthique et le droit répondent à la science », dans Daniel TURP et Gérald A. BEAUDOIN (dir.), *Perspectives canadiennes et européennes des droits de la personne*, Cowansville (Qc), Yvon Blais, 1986, p. 445, à la page 457 ; Bartha Maria KNOPPERS, « Modern Birth Technology and Human Rights » (1985), 33 *Am. J. Comp. L.* 1, 16-17 ; Edward W. KEYSERLINGK, *The Unborn Child's Right to Prenatal Care: A Comparative Law Perspective*, Montréal, Centre de recherche en droit privé et comparé du Québec, 1984, pp. 57-59.

271. J.-L. BAUDOUIN et C. LABRUSSE-RIOU, *op. cit.*, note 214, p. 57 ; B.M. KNOPPERS, *loc. cit.*, note 270, 16-17 :

> [TRADUCTION]
> En common law, la protection de l'enfant non encore né contre le préjudice causé par la négligence a fait son apparition dans le contexte des droits de propriété et successoraux dont était investi l'enfant à compter de la conception, à condition qu'il naisse vivant [. . .] De même, la common law des États-Unis et du Canada a retenu soit une obligation préexistante de ne causer aucun préjudice, soit une obligation conditionnelle prospective qui se cristallise à la naissance et devient la base de la responsabilité délictuelle. Un autre concept a récemment fait son apparition en common law — celui de la causalité — qui sépare les concepts de préjudice et de dommage, et s'intéresse simplement au lien de causalité entre l'état dans lequel naît l'enfant et le fait du défendeur.

B.M. DICKENS, *loc. cit.*, note 225, 262 :

> [TRADUCTION]
> La common law a reconnu récemment la responsabilité pour le préjudice causé avant la conception, de sorte que le fait que l'ovocyte ait été fécondé ou non au moment où le préjudice a été causé pourrait ne pas entrer en ligne de compte. Cela dit, la reconnaissance du délit antérieur à la conception est très récente et tire son origine de décisions américaines. Par conséquent, son application au Canada est forcément problématique.

Cependant, l'anonymat du donneur, les problèmes de preuve et la difficulté d'établir le lien de causalité rendront presque toujours ce recours illusoire[272], d'autant que l'action en responsabilité pourra beaucoup plus facilement être intentée contre la banque de gamètes et d'embryons pour son défaut dans la sélection ou le dépistage, ou encore contre le médecin traitant.

Quoi qu'il en soit, signalons que la responsabilité du donneur revêt une dimension d'ordre public[273]. La responsabilité criminelle du donneur pourrait en effet être engagée si par exemple ce dernier, se sachant porteur d'un virus pouvant causer la mort, donnait néanmoins son sperme et cachait intentionnellement cette information. À cet effet, il est donc important que le donneur soit au moins identifiable et que l'anonymat puisse être levé en cas de poursuite criminelle découlant de sa réticence.

C. L'enfant

1. La filiation juridique

Le système de la filiation juridique organise les liens de droit qui unissent l'enfant à ses père et mère[274]. À la filiation s'attachent en effet certains droits et obligations, telle

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Voir *Jorgensen* c. *Meade Johnson Laboratories, Inc.*, 483 F. 2d 237, 240 (1973), où le juge Holloway a conclu ce qui suit :

> [TRADUCTION]
> Si l'on devait retenir la position suivant laquelle l'acte de nature délictuelle accompli avant la conception ne donne ouverture à aucune action au nom de l'enfant qui subit ultérieurement le préjudice, cela voudrait dire que le nouveau-né qui subit un préjudice personnel à cause d'un produit alimentaire défectueux fabriqué avant sa conception ne disposerait d'aucun recours. Or, une telle conclusion est contraire aux principes de redressement que l'Oklahoma offre aux personnes subissant un préjudice dont la cause prochaine est un produit ou accessoire alimentaire défectueux, fabriqué et mis en marché par le défendeur. [...]
>
> Nous sommes convaincus que les tribunaux de l'Oklahoma verraient dans le préjudice dont il est question en l'espèce une question de lien de causalité et de cause prochaine, susceptible d'être tranchée sur la base d'une preuve médicale valide. [...] D'ailleurs, cette conception du problème s'accorde avec la position prédominante qui reconnaît la recevabilité de l'action visant le préjudice infligé par négligence avant la naissance, si l'enfant qui subit le préjudice naît vivant.

Voir également *Renslow* c. *Mennonite Hospital*, 351 N.E. 2d 870 (1976).

272. Bartha M. KNOPPERS et Elizabeth SLOSS, « Recent Developments: Legislative Reforms in Reproductive Technology » (1986), 18 *Rev. d'Ottawa* 663, 687-688.

273. *R.* c. *Thornton*, C. distr. Ontario, n° 1814, 15 juin 1989, j. Flanigan, conf. par (1991) 1 O.R. (3e) 480 (C.A.). Dans ce jugement très récent de la Cour de district d'Ottawa, l'accusé a été reconnu coupable de nuisance publique pour avoir donné volontairement de son sang alors qu'il se savait porteur du virus du sida.

274. Voir Mireille D.-CASTELLI, *Précis du droit de la famille*, Québec, P.U.L., 1987, p. 119.

l'obligation des parents de nourrir, entretenir et éduquer leurs enfants. Le droit tire aussi de la filiation des conséquences en matière de successions. Le lien de droit peut découler du lien biologique (filiation par le sang), ou encore se créer par la volonté (adoption). Or, comment doit s'établir la filiation des enfants nés de la procréatique ?

Traditionnellement, l'établissement de la filiation maternelle par le fait de l'accouchement[275] traduisait une certitude biologique et génétique. Le mariage, certitude sociale, permettait de résoudre l'incertitude de la paternité par une présomption qui, bien que favorisant l'aspect social de la paternité, reflétait la plupart du temps la réalité biologique.

Certains législateurs ont, au fil des ans, tempéré les règles traditionnelles de la filiation en abolissant la distinction entre l'enfant naturel et l'enfant légitime[276] et en reconnaissant la préséance de la vérité biologique.

Parmi les provinces de common law, il y aurait cependant une certaine disparité entre celles qui établissent la filiation sur la seule base du mariage et celles où le législateur est venu assouplir cette règle de common law en abolissant la distinction entre les enfants naturels et les enfants légitimes[277]. Soulignons, toutefois, que ces changements ont donné

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275. *Ibid.* En common law, voir B.M. DICKENS, *loc. cit.*, note 222, 69-70, et B.M. KNOPPERS, *loc. cit.*, note 225, 339-340. Cette conception traditionnelle de notre droit s'exprime par la maxime *Mater est quam gestatio demontrat*. Voir John K. MASON et Robert A. MCCALL-SMITH, *Law and Medical Ethics*, 2e éd., Londres, Butterworths, 1987, p. 47.

276. En droit civil, voir M. D.-CASTELLI, *op. cit.*, note 274, p. 122, et, en common law, Margo WILSON, « Impact of the Uncertainty of Paternity on Family Law » (1987), 45 *U.T. Fac. L. Rev.* 216, 232 ; voir *infra*, note 286.

277. *Canadian Family Law Guide*, Don Mills, Commerce Clearing House Canadian, 1989, p. 2401, par. 4305 ; voir *infra*, note 286. Une décision de la Colombie-Britannique, *Gartrell* c. *Carlsen* (1987), 13 B.C.L.R. (2e) 56 (C. prov.), a établi ce qui suit : [TRADUCTION] « Depuis l'adoption du paragraphe 56(1) du *Law and Equity Act* de la Colombie-Britannique, la filiation biologique est la seule que reconnaît le droit de cette province et la présomption de légitimité s'est trouvée abolie. »

Voici la teneur du par. 56(1) du *Law and Equity Act*, R.S.B.C. 1979, ch. 224, mod. par S.B.C. 1985, ch. 68, art. 80 :

> [TRADUCTION]
> Sous réserve des dispositions du *Adoption Act* et du *Family Relations Act*, les règles suivantes s'appliquent à toutes fins que de droit dans les matières relevant de la compétence de la province :
>
> *a*) chacun est l'enfant de ses parents naturels ;
>
> *b*) est abolie toute distinction entre l'enfant né à l'intérieur du mariage et l'enfant né en dehors du mariage ;
>
> *c*) les liens de filiation, de même que les liens de parenté qui en résultent, sont établis conformément au présent paragraphe.

lieu, tant au Québec que dans les provinces de common law, à une controverse quant au poids relatif qu'il convient d'accorder aux divers modes de preuve de la filiation[278].

De fait, il est permis de douter que l'intention du législateur fût vraiment de choisir entre les aspects biologique et social de la filiation. En effet, que ce soit en établissant la certitude de la maternité et la présomption de paternité, ou en éliminant la distinction entre l'enfant naturel et l'enfant légitime, le législateur avait-il pour but de préserver l'intérêt de l'enfant, ou était-il davantage préoccupé par une application plus claire des règles de droit ?

S'il est difficile de déterminer ce que doivent refléter les règles actuelles de la filiation (vraisemblance sociale ou vérité biologique) — tout autant que de cerner l'intention du législateur — il devient d'autant plus complexe d'appliquer et d'adapter ces règles à la procréation médicalement assistée. Parmi des problèmes qui peuvent surgir, pensons à l'attribution des responsabilités découlant de la paternité à un mari qui n'a pas consenti à la conception de l'enfant (ou encore au donneur qui n'a aucunement l'intention

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Cela porte à croire que, dans les provinces où cette distinction traditionnelle n'a pas été abolie, le droit dissimulerait toujours la vérité biologique sous la présomption de légitimité reliée au mariage et favoriserait ainsi la réalité sociale. Cependant, la Cour suprême de la Colombie-Britannique a émis l'opinion suivante dans *B. (B.J.)* c. *K. (J.)* (1989), 56 D.L.R. (4e) 150, 158 :

> [TRADUCTION]
> S'il est juste de dire que l'art. 56 du *Law and Equity Act*, en abolissant « toute distinction entre l'enfant né à l'intérieur du mariage et l'enfant né en dehors du mariage », a eu pour effet d'abolir l'état d'illégitimité [...], il n'a certainement pas eu pour effet d'abolir les réalités que nous désignons au moyen des termes « légitimité » et « illégitimité ». [...]
>
> Il eût fallu pour cela, à mon avis, l'expression claire et non équivoque de l'intention du législateur d'écarter une présomption qui existe depuis aussi longtemps et qui, selon moi, constitue une règle utile et équitable [...]
>
> Comme l'article 56 du *Law and Equity Act* ne contient aucune expression claire et non équivoque de cette intention, j'en conclus que la présomption de légitimité existe toujours en Colombie-Britannique.

278. Au Québec, voir Jean PINEAU, *La Famille*, Montréal, P.U.M., 1982, pp. 198-202 ; Michèle RIVET, « La vérité et le statut juridique de la personne en droit québécois » (1987), 18 *R.G.D.* 843, 848 : l'auteure commente l'affaire *Trudeau* c. *Arial*, [1981] C.S. 727, *Droit de la famille-6*, J.E. 83-76 (C.A.) ; B.M. KNOPPERS, *loc. cit.*, note 263, 829, illustre bien l'ambivalence du Code civil à ce sujet. En common law, voir *supra*, note 277, ainsi que le rapport de la CRDO, *op. cit.*, note 2, pp. 64-78.

d'être père[279]), au désaveu d'un enfant initialement voulu[280] par des parents qui, en cours de traitement, changent d'idée, ainsi qu'à la possibilité d'une contestation de paternité par des tiers ou le donneur et d'une réclamation de paternité de la part de ce dernier[281].

D'autre part, l'application des règles actuelles de la filiation aux techniques qui comportent le don d'un ovule vient, pour la première fois, scinder la filiation biologique maternelle en dissociant la maternité génétique de la maternité gestatrice. Cette situation place le législateur devant un choix que nul n'aurait pu prévoir : faut-il faire prévaloir la gestation et l'accouchement sur l'appartenance génétique ?

2. La filiation biologique

L'enfant peut vouloir connaître ses origines soit pour être au courant des antécédents médicaux de ses géniteurs, soit pour satisfaire un besoin psychologique d'identité. Nous pouvons facilement affirmer que l'intérêt de l'enfant à connaître ses antécédents médicaux et génétiques soulève peu d'opposition dans notre société[282]. Cependant, en pratique, l'accès à cette information n'est pas garanti :

> [TRADUCTION]
> Les régimes législatifs actuels présentent une lacune majeure en ce que, même lorsqu'ils tiennent compte des préférences des principaux intéressés à la procréation assistée, comme dans le cas de l'IAD [insémination artificielle avec sperme de donneur], ils ne protègent pas nécessairement l'enfant qui naît par suite du traitement. [...] Un problème encore

279. Voir à titre d'exemple l'al. 56(1)*a*) du *Law and Equity Act*, précité, note 277.

280. Sous réserve au Québec de l'art. 586 C.c.Q., au Yukon du par. 13(3) du *Children's Act*, précité, note 201, et à Terre-Neuve du par. 12(3) du *The Children's Law Act*, précité, note 201.

281. Voir B.M. DICKENS, *loc. cit.*, note 222, 68 ; ASSOCIATION DU BARREAU CANADIEN, *Report of the Special Task Force Committee on Reproductive Technology of the British Columbia Branch*, 1989, p. 13 [non publié]. Voir les art. 586 et 588 C.c.Q. et l'art. 580 du projet de loi 125, précité, note 200. Le Yukon a cependant prévu l'absence de lien de droit entre le donneur et l'enfant né de son don si le premier n'est pas le mari de la mère : *Children's Act*, précité, note 201, par. 13(6). La loi modifiant la loi uniforme sur le statut de l'enfant, précitée, note 203 prévoit ce qui suit au par. 11.4(2) : [TRADUCTION] « L'homme dont le sperme est utilisé pour la conception assistée d'un enfant dont il n'est pas présumé être le père en application de l'article 9 est réputé ne pas être le père de cet enfant. » L'art. 579 du projet de loi 125, précité, note 200, est au même effet : « La contribution au projet parental d'autrui par un apport de forces génétiques à la procréation médicalement assistée ne permet de fonder aucun lien de filiation entre l'auteur de la contribution et l'enfant issu de cette procréation. »

282. J.-L. BAUDOUIN et C. LABRUSSE-RIOU, *op. cit.*, note 214, p. 55 ; Bernard M. DICKENS, « Legislating for the Brave New Children », dans Barbara LANDAU (dir.), *Children's Rights in the Practice of Family Law*, Toronto, Carswell, 1986, p. 345, à la page 347. Afin que des dossiers sur les origines génétiques des enfants nés de la procréation médicalement assistée soient tenus et que l'accès à ces dossiers soit rendu possible, la loi modifiant la loi uniforme sur le statut de l'enfant, précitée, note 203, prévoit ce qui suit à l'art. 11.6 :

plus grave se pose lorsque l'un des gamètes utilisés ou les deux proviennent de donneurs. La connaissance de la filiation génétique de l'enfant pourra être essentielle lorsqu'il s'agira de lui appliquer des soins médicaux ou de le conseiller en matière de procréation. L'impossibilité de retrouver ne serait-ce que le profil génétique des parents biologiques pourrait placer l'enfant dans une situation défavorable, voire dangereuse. La formule de l'adoption peut tourner au désavantage de l'enfant, mais elle permet habituellement de retracer au moins les caractéristiques de la mère biologique. La conception au moyen de gamètes provenant de donneurs met au jour la carence du législateur qui expose un nombre grandissant d'enfants à des risques graves pour leur santé[283].

De plus, l'accès à ces renseignements, dans l'hypothèse où ils seraient disponibles, pose le problème de la divulgation de l'intervention d'un tiers dans la conception. Nous devons en effet décider si la révélation de cette circonstance doit être laissée à la discrétion des parents ou faire l'objet d'un droit reconnu à l'enfant devenu majeur.

Pour ce qui est de l'intérêt de l'enfant au regard de son besoin psychologique d'identité, cette notion ne nous est pas étrangère. En effet, le droit de connaître ses origines est de plus en plus reconnu en matière d'adoption. Des systèmes ont été mis en place pour permettre aux enfants adoptés de rechercher leurs parents biologiques[284]. En matière de

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[TRADUCTION]

(1) Il incombe au médecin qualifié qui accomplit un acte dans le cadre d'un traitement de conception assistée de tenir, suivant la forme et la manière prescrites par règlement, un dossier indiquant l'identité du donneur ou de la donneuse et de la receveuse de tout ovule ou dose de sperme utilisé pour le traitement.

(2) Il incombe au médecin qualifié qui accomplit un acte destiné à provoquer une conception assistée de présenter l'information dont il dispose relativement aux faits suivants :

a) toute conception assistée résultant d'un traitement administré par lui,

b) toute naissance résultant d'une conception assistée provoquée par un acte accompli par lui,

c) tout acte accompli par lui et destiné à provoquer une conception assistée, lorsqu'il ne sait pas si la conception en est résultée ou non.

(3) Il incombe au médecin qualifié de présenter l'information dont il dispose au sujet de la naissance de tout enfant mis au monde par lui et résultant d'une conception assistée.

(4) L'information mentionnée aux paragraphes (2) et (3) est présentée à l'organisme désigné par règlement, suivant la forme et la manière, et au moment prescrits par règlement.

(5) L'organisme qui reçoit l'information en application du paragraphe (4) :

a) tient un registre permanent contenant cette information,

b) s'abstient de divulguer ou de communiquer l'information sauf conformément aux modalités prévues par règlement.

(6) Le lieutenant gouverneur en conseil [ou toute autre autorité réglementaire compétente] peut, par règlement, prescrire toute chose qui, aux termes du présent article, peut ou doit être prescrite par règlement.

283. B.M. DICKENS, *loc. cit.*, note 282, 355 ; voir aussi B.M. KNOPPERS, *loc. cit.*, note 270, 15, n. 64.

284. Au Québec, par exemple, un sommaire des antécédents de l'adopté peut être remis à l'adoptant et à l'adopté lui-même s'il est âgé de quatorze ans ou plus, dans la mesure où l'anonymat est respecté (*Loi sur la protection de la jeunesse*, L.R.Q., ch. P-34.1, art. 131.1, 131.2). De plus, le législateur prévoit des retrouvailles

procréation médicalement assistée, toutefois, la confusion qui entoure la tenue des dossiers, ajoutée au principe de la « protection » de l'anonymat du donneur, a pour effet de nier à l'enfant le droit de connaître ses origines[285].

Nous devons nous demander, en premier lieu, s'il est opportun de comparer la situation de l'enfant conçu grâce à un don à celle de l'enfant adopté, et, en second lieu, s'il convient de reconnaître aussi au premier le droit de connaître ses origines ou certains droits à l'information. Quelle que soit la réponse, il est important d'en arriver à un compromis afin que la vie privée du donneur et des parents soit protégée. À défaut d'accorder un droit formel à l'information, on pourrait à tout le moins prévoir la levée de l'anonymat dans certaines circonstances.

3. Le statut juridique

Si la majorité des provinces et territoires canadiens ont éliminé la distinction entre l'enfant légitime et l'enfant illégitime[286], certaines provinces, telles l'Alberta et la Nouvelle-Écosse, résistent encore à cette tendance.

Dans ces provinces, l'enfant conçu grâce à un don de gamètes ou d'embryon se verra privé des avantages attribués à l'enfant légitime, non seulement dans les cas où ses parents ne sont pas mariés, mais aussi dans les cas où la preuve est faite qu'un donneur est à

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entre parents biologiques et adoptés majeurs consentants (art. 632 C.c.Q.). Cette recherche doit tenir compte de l'intention des parties. Voir par exemple l'art. 632 C.c.Q. (repris à l'art. 577 du projet de loi 125, précité, note 200) et, en Ontario, MINISTÈRE DES SERVICES SOCIAUX ET COMMUNAUTAIRES, *Services de divulgation des renseignements sur les adoptions*, Toronto, Imprimeur de la Reine pour l'Ontario, 1987. Signalons toutefois qu'au Québec, l'art. 583 du projet de loi 125, prévoit la confidentialité des renseignements identifiants relatifs à la conception médicalement assistée d'un enfant. Une exception est prévue lorsque la confidentialité risque de causer un préjudice grave à la santé de l'enfant.

285. Aux États-Unis, les auteurs d'une étude ont estimé que seulement un peu plus du tiers des médecins interrogés conservaient des dossiers permanents sur les enfants conçus par insémination artificielle, et que moins d'un tiers tenaient des dossiers permanents sur les donneurs. Voir Martin CURIE-COHEN, Lesleigh LUTTRELL et Sander SHAPIRO, « Current Practice of Artificial Insemination by Donor in the United States » (1979), 300:11 *New Engl. J. Med.* 585, 588, cité dans Ann T. LAMPORT, « The Genetics of Secrecy in Adoption, Artificial Insemination, and *In Vitro* Fertilization » (1988), 14:1 *Am. J. L. Med.* 109, 116-117 ; on trouve le passage suivant à la p. 118 : [TRADUCTION] « Il arrive souvent que le sperme utilisé pour l'insémination artificielle soit recueilli par un urologue et que l'insémination soit effectuée par un obstétricien qui n'est pas nécessairement celui qui mettra l'enfant au monde. »

286. Au Québec, le C.c.Q. a supprimé les inégalités existant entre les différentes sortes de filiation connues — légitime, naturelle et adultérine. Voir l'art. 594 C.c.Q. (repris à l'art. 536 du projet de loi 125, précité, note 200). Voir aussi *Law and Equity Act* (C.-B.), précité, note 277, par. 56(1) ; *Child Status Act*, R.S.P.E.I. 1988, ch. C-6, par. 1(1), 1(4) ; *Loi sur les services à la famille*, L.N.-B. 1980, ch. F-2.2, art. 96(1), 96(4) ; *Loi sur l'obligation alimentaire*, L.R.M. 1987, ch. F20, art. 17 ; *Loi portant réforme du droit de l'enfance*, précitée, note 232, par. 1(1), 1(4), 2(1) ; *Loi sur l'organisation judiciaire*, L.R.T.N.-O. 1988, ch. J-1 ; *Children's Act* (Yukon), précité, note 201, par. 5(1), 5(4) ; *The Children's Law Act* (T.-N.), précité, note 201, art. 3 ; *The Children's Law Act*, S.S. 1990, ch. C-8.1, art. 40. Voir finalement la loi uniforme sur le statut de l'enfant, précitée, note 203, art. 2.

l'origine de sa conception[287] (et ce, malgré le fait que l'insémination artificielle hétérologue ne soit plus considérée comme un adultère). Même si la présomption de paternité a pour effet, dans le contexte de cette technique, de faire du mari le père légitime de l'enfant, peut-être serait-il préférable de clarifier le statut juridique de l'enfant né d'un don de gamètes ou d'embryon :

> [TRADUCTION]
> Là où la distinction existe toujours entre l'enfant légitime et l'enfant illégitime, l'enfant né à la suite d'une IAD [insémination artificielle avec sperme de donneur] est tenu pour illégitime, avec tout ce que cela comporte de désavantages sur le plan de ses rapports avec sa famille sociale. Aussi le recours à l'IAD est-il souvent caché, parce que l'enfant que met au monde une femme mariée est légalement présumé être l'enfant du mari, et que personne n'a intérêt à réfuter cette présomption[288].

D. Les intervenants médicaux

1. La responsabilité du médecin

Le médecin qui fait preuve de négligence dans l'administration d'un traitement engage sa responsabilité. Il n'est toutefois tenu qu'à une obligation de moyens et non à une obligation de résultat[289].

En matière de procréation médicalement assistée, la négligence du médecin peut entrer en jeu avant ou après la conception. Elle peut porter soit sur l'application de la technique, soit sur l'exécution de l'obligation d'informer[290], soit sur le respect de la confidentialité[291]. Dans la présente étude, nous nous attarderons plus particulièrement à l'obligation d'informer, obligation qui découle du devoir de tout médecin d'obtenir le consentement libre et éclairé de son patient[292].

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287. Bartha Maria KNOPPERS, « Women and the Reproductive Technologies », [1985] *Fam. L. Can.* 211, 220 ; reste toujours la possibilité d'une requête en légitimation : *Legitimacy Act*, R.S.A. 1980, ch. L-11 ; *Family Maintenance Act*, R.S.N.S. 1989, ch. 160, art. 49.

288. B.M. DICKENS, *loc. cit.*, note 282, 347.

289. J.-L. BAUDOUIN et C. LABRUSSE-RIOU, *op. cit.*, note 214, p. 57.

290. *Ibid.* ; E.I. PICARD, *op. cit.*, note 200, p. 67 et suiv.

291. J.-L. BAUDOUIN et C. LABRUSSE-RIOU, *op. cit.*, note 214, p. 58 ; G. SHARPE, *op. cit.*, note 259, p. 181 et suiv. Cette question a déjà été discutée ; voir *supra*, p. 60.

292. La nécessité du consentement relève de l'application de la règle sanctionnée à la fois par le droit civil, la common law et le droit criminel, et suivant laquelle on ne peut porter atteinte à l'intégrité physique d'une personne sans son consentement. En matière pénale, voir CRD, *Pour une nouvelle codification du droit pénal — édition révisée et augmentée du rapport n° 30*, Rapport n° 31, Ottawa, la Commission, 1987, p. 70.

La portée de cette obligation semble varier selon que le traitement en cause est de nature thérapeutique, élective ou expérimentale. En effet, bien que la Cour suprême du Canada[293] n'ait fait aucun commentaire spécifique à cet égard dans les arrêts *Reibl* c. *Hughes* et *Hopp* c. *Lepp*[294], certaines autres décisions, tant en droit civil qu'en common law, s'accordent pour attribuer une portée plus vaste à l'obligation d'informer dans le contexte de la chirurgie élective[295].

En matière de recherche, l'obligation de divulguer l'information et les risques serait encore plus rigoureuse: [TRADUCTION] « Non seulement le sujet doit consentir, mais encore son consentement doit être explicite et reposer sur une divulgation que l'on pourrait qualifier de "parfaite"[296]. »

La question que pose la procréatique est donc celle de savoir si les différentes techniques sont de nature thérapeutique, élective ou expérimentale et, selon le cas, quelle norme de divulgation il y a lieu d'appliquer.

Bien que la qualification des techniques de procréation assistée sous ce rapport déborde le cadre de notre étude, nous nous permettons néanmoins de recommander aux tribunaux appelés à résoudre cette question de tenir compte des particularités de chaque technique (risques, taux de succès, etc.)[297].

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293. E.I. PICARD, *op. cit.*, note 200, p. 92.

294. Précités, note 242.

295. En common law, voir E.I. PICARD, *op. cit.*, note 200, p. 93,

> [TRADUCTION]
> Appelés à interpréter l'arrêt de la Cour suprême du Canada dans l'affaire *Reibl* c. *Hugues* [précitée, note 242], les tribunaux provinciaux ont décidé que, dans le cas d'une intervention de nature élective, les risques, même mineurs ou très faibles, ainsi que les solutions de rechange et leur dangerosité relative devaient être divulgués volontairement. [...] Suivant une certaine jurisprudence, le médecin qui procède à une stérilisation est tenu de divulguer les autres méthodes ou techniques qui s'offrent au patient. Il semble que l'on puisse étendre cette règle à toute intervention élective.

En droit civil, voir *Blais* c. *Dion*, J.E. 85-934, p. 11 (C.S.) ; *Dulude* c. *Gaudette*, [1974] C.S. 618, 621 ; *Hamelin Hankins* c. *Papillon*, [1980] C.S. 879, 881. À propos de la controverse actuelle au sujet des risques à divulguer en matière de chirurgie plastique, voir Louise POTVIN, *L'obligation de renseignement du médecin*, Cowansville (Qc), Yvon Blais, 1984, pp. 29-31.

296. E.I. PICARD, *op. cit.*, note 200, p. 118. Voir aussi *L'expérimentation biomédicale sur l'être humain*, *op. cit.*, note 7, p. 33 et suiv. Au Canada, c'est la décision rendue dans *Halushka* c. *University of Saskatchewan* (1965), 53 D.L.R. (2e) 436 (C.A. Sask.), qui a établi la norme et l'étendue de l'obligation de divulguer en matière d'expérimentation ; voir p. 444 : [TRADUCTION] « Le sujet d'une expérience médicale a droit à la divulgation franche et complète de tous les faits, probabilités et opinions qu'une personne raisonnable voudrait censément prendre en considération avant de donner son consentement. [...] Les exceptions qu'admet la pratique usuelle de la médecine à la règle de la divulgation ne peuvent trouver leur application dans le cas de la recherche. »

Voir aussi la décision rendue récemment par la Cour supérieure du Québec dans *Weiss* c. *Solomon*, [1989] R.J.Q. 731.

297. Voir *supra*, ch. I.

2. La responsabilité des banques de gamètes et d'embryons

La sélection des donneurs est primordiale puisque non seulement elle augmente les chances de succès, mais elle protège la santé de la personne qui reçoit le don et évite la transmission de certaines maladies infectieuses ou génétiques graves[298]. C'est d'ailleurs depuis la découverte de la possibilité de transmission du sida par le sperme que les médecins se sont mis à utiliser du sperme congelé aux fins d'insémination.

Les banques de gamètes et d'embryons peuvent engager leur responsabilité si elles font preuve de négligence dans le dépistage des affections ou maladies génétiques, par exemple. En droit civil, [TRADUCTION] « le laboratoire est tenu à une obligation de résultat et, en cas d'erreur, devra faire la preuve de l'intervention d'un facteur ou d'un événement extérieur pour s'exonérer[299]. » En common law, [TRADUCTION] « comme la norme de diligence est proportionnelle aux risques en jeu, cette norme pourrait très bien être la même[300]. »

Contrairement au don d'autres produits humains tels que le sang[301], le don de gamètes ou d'embryon ne fait présentement l'objet d'aucune réglementation nationale. En 1977, un comité consultatif s'est intéressé à la question du stockage et de l'utilisation du sperme humain ; il a présenté, en 1981, un rapport au ministre de la Santé nationale et du Bien-être social. Dans une de ses recommandations, le comité proposait « que des règlements gouvernant les normes d'acquisition, de préservation et d'importation du sperme humain soient établis au niveau fédéral[302] ». En 1988, la Société canadienne de fertilité et d'andrologie a adopté des lignes directrices concernant, entre autres, la sélection des donneurs et le dépistage génétique. Toutefois, comme l'indique la préface, le texte en

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298. Lori B. ANDREWS, *Medical Genetics: A Legal Frontier*, Chicago, American Bar Foundation, 1987, p. 168 : [TRADUCTION] « [C]ertaines femmes ont contracté des maladies vénériennes parce qu'elles avaient été inséminées avec le sperme de donneurs atteints de ces maladies. De plus, on a vu des enfants naître avec des affections génétiques transmises par le sperme du donneur. » Andrews renvoie à William G. JOHNSON, Robin C. SCHWARTZ et Abe M. CHUTORIAN, « Artificial Insemination by Donors: The Need for Genetic Screening » (1981), 304:13 *New Engl. J. Med.* 755 ; David N. SHAPIRO et Raymond J. HUTCHINSON, « Familial Histiocytosis in Offspring of Two Pregnancies after Artificial Insemination » (1981), 304:13 *New Engl. J. Med.* 757. Voir également *supra*, ch. I.

299. B.M. KNOPPERS, *loc. cit.*, note 270, 10, n. 47.

300. *Ibid.*

301. La *Loi sur les aliments et drogues*, L.R.C. (1985), ch. F-27, et ses règlements (C.R.C. 1978, ch. 870) établissent des normes concernant, entre autres, la publicité, l'étiquetage, la vente, l'importation, le traitement, l'entreposage et le nombre de dons permis. La Société canadienne de la Croix-Rouge a également établi des normes sur certains de ces sujets ; voir *Prélèvement et utilisation médicale de tissus et d'organes humains*, *op. cit.*, note 254.

302. *Rapport sur le sperme humain de 1981*, *op. cit.*, note 149, p. xii.

question « n'a pas la prétention d'être exhaustif ni de faire autorité. Il ne doit pas non plus être un ensemble rigide de règles et de méthodes[303]. »

L'évolution rapide de la médecine rend toutefois difficiles la réglementation de la sélection médicale et la prescription d'épreuves de dépistage génétique. Par contre, la très grande incertitude qui entoure l'application des critères de sélection et des normes de conservation et d'importation constitue un risque pour l'enfant à naître et les futurs parents. Il est donc important de déterminer à qui doit revenir la tâche de réaliser l'uniformité des normes utilisées et de quelle façon. Le corps médical pourrait-il à lui seul s'en charger ?

De leur côté, les banques de gamètes et d'embryons se doivent de respecter le consentement du donneur et peuvent engager leur responsabilité si elles font preuve de négligence dans la conservation des gamètes et des embryons.

Nous avons vu que de nombreuses règles de droit s'appliquent à la procréation médicalement assistée mais que, la plupart du temps, elles ne sont pas adaptées à cette nouvelle réalité. Au chapitre des recommandations, nous tenterons de répondre aux problèmes posés dans cette première section. Nous allons maintenant examiner de façon particulière les problèmes que pose la maternité de substitution.

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303. SOCIÉTÉ CANADIENNE DE FERTILITÉ ET D'ANDROLOGIE, *op. cit.*, note 11, p. 3 ; la pratique actuelle se caractérise donc par l'incertitude quant à l'application de critères uniformes. La CRDO soulignait en 1985 :

> [TRADUCTION]
> Pour ce qui est de la sélection des donneurs par les médecins, la pratique varie considérablement. Les analyses les plus courantes, qui sont effectuées soit par le médecin, soit par le laboratoire à la demande de celui-ci, sont celles du groupe et du type sanguin, l'analyse et la culture du sperme, et le test VDRL [Venereal Disease Research Laboratory]. Parmi les analyses moins courantes, citons la formule sanguine et le dépistage de l'hépatite, ainsi que, plus rarement encore, le caryotype, le dépistage génétique et l'examen des antécédents familiaux et généraux du donneur. Certains médecins ont mentionné d'autres types d'analyse.

CRDO, *op. cit.*, note 2, p. 22.

De plus, la capacité du praticien d'effectuer une sélection génétique convenable soulève des doutes. Voir A.T. LAMFORT, *loc. cit.*, note 285, 117. L'auteure renvoie à M. CURIE-COHEN, L. LUTTRELL et S. SHAPIRO, *loc. cit.*, note 285, 588 :

> [TRADUCTION]
> Les généticiens, entre autres, reconnaissent que l'insémination artificielle est souvent confiée à des praticiens dont la connaissance de la génétique présente des lacunes graves. Le dépistage des affections congénitales chez les donneurs est courant mais illusoire. On examine les antécédents familiaux, mais habituellement de façon superficielle. Les analyses biochimiques ne sont effectuées que dans 28,8 pour 100 des cas. [...] Parmi les médecins participant à l'étude Curie-Cohen, 92 pour 100 ont affirmé qu'ils écarteraient un donneur présentant une translocation de chromosome ou une trisomie, mais seulement 12,5 pour 100 ont effectivement examiné le caryotype du donneur éventuel afin de déceler toute anomalie chromosomique. D'autre part, 71,4 pour 100 ont déclaré qu'ils écarteraient un donneur dont les antécédents familiaux révèlent des cas d'hémophilie, bien qu'il s'agisse d'un caractère lié au chromosome X et qu'il soit impossible à un homme de le transmettre à moins d'être porteur de la maladie et d'en être atteint.

Lamport précise qu'il s'agit de la seule étude de ce type réalisée jusqu'à maintenant. Voir également, C.L.R. BARRATT, M. CHAUHAN et I.D. COOKE, *loc. cit.*, note 164, et le texte sous la rubrique « La sélection des gamètes et des embryons », *supra*, p. 37.

II. La maternité de substitution

A. Les principes en cause

1. La légalité et la légitimité[304]

Dans l'état actuel du droit, le phénomène de la maternité de substitution déroge aux principes du droit des contrats. En effet, aussi bien en droit civil qu'en common law, l'entente conclue, même à titre gratuit, entre une femme porteuse et les futurs parents est fort probablement nulle de nullité absolue, parce que contraire à l'ordre public et sans objet[305]. Mentionnons de plus qu'un tel contrat est également contraire à un principe fondamental du droit de la famille : la garde de l'enfant doit être déterminée en fonction de l'intérêt véritable de l'enfant et non des vœux des parents exprimés dans un contrat[306]. Les dispositions relatives à l'autorité parentale[307] rendent illégale toute convention prévoyant à l'avance la remise de l'enfant à qui que ce soit à sa naissance.

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304. Voir *supra*, note 235.

305. En common law, voir B.M. DICKENS, *loc. cit.*, note 222, 71 : [TRADUCTION] « Il est généralement reconnu que, en l'absence de législation les rendant valides, les ententes de maternité de substitution seront tenues pour nulles par les tribunaux, parce que contraires à l'intérêt public. » CRDO, *op. cit.*, note 2, p. 220 : [TRADUCTION] « Bien qu'ils ne soient pas expressément interdits, il semble que ces accords soient illégaux et inexécutables en common law. » En droit civil, voir J.-L. BAUDOUIN et C. LABRUSSE-RIOU, *op. cit.*, note 214, p. 115 ; l'art. 582 du projet de loi 125, précité, note 200, prévoit sa nullité de façon explicite : « Les conventions de procréation ou de gestation pour le compte d'autrui sont nulles. » Rappelons également la décision américaine *Baby M*, 537 A. 2d 1227, 1234 (N.J. 1988) : [TRADUCTION] « Nous tenons le contrat de maternité de substitution pour invalide parce qu'il contrevient au droit et aux objectifs publics de l'État. »

306. La préséance de l'intérêt véritable de l'enfant sur la liberté contractuelle est rendue évidente par des dispositions tels les al. 52(1)c) et 53(1)c), et le par. 56(1) de la *Loi de 1986 sur le droit de la famille* de l'Ontario, précitée, note 200 ; à titre d'exemple, voici la teneur de l'al. 52(1)c) :

> 52. (1) Un homme et une femme qui sont mariés ensemble ou qui ont l'intention de se marier peuvent conclure un accord afin de convenir de leurs obligations et droits respectifs dans le cadre du mariage ou lors de leur séparation, de l'annulation ou de la dissolution du mariage, ou du décès, y compris :
> [. . .]
> *c*) le droit de diriger l'éducation et la formation morale de leurs enfants, mais non le droit de garde ou de visite ;
> [. . .]

L'alinéa 53(1)c) établit la même règle à l'égard de l'homme et de la femme « qui cohabitent ou ont l'intention de cohabiter ». Quant au par. 56(1), en voici le libellé : « Le tribunal peut, lorsqu'il règle une question relative aux aliments dus à un enfant, à son éducation, à sa formation morale ou à un droit de garde ou de visite, passer outre à une disposition d'un contrat familial qui a trait à cette question s'il est d'avis que cette mesure est dans l'intérêt véritable de l'enfant. »

307. En common law, voir le rapport de la CRDO, *op. cit.*, note 2, p. 99 : [TRADUCTION] « [P]our ce qui est de la common law [. . .], il est établi depuis longtemps en jurisprudence que, sous réserve de quelques rares exceptions, les droits et obligations des parents sont inaliénables et ne peuvent être cédés par contrat. » La légalité d'une telle convention dépendrait avant tout de l'intérêt de l'enfant. Ainsi, la Cour suprême a reconnu que certaines conventions de garde, dont le but premier était l'intérêt véritable de l'enfant, n'étaient pas illégales ; voir *Chisholm* c. *Chisholm* (1908), 40 R.C.S. 115. *Contra : Re Hutchinson* (1913), 28 O.L.R. 114 (C.A.). Voir la discussion concernant le contrat de maternité de substitution et le transfert de garde d'enfant dans le rapport de la CRDO, *op. cit.*, note 2, pp. 94-102. En droit civil, voir M. RIVET, *loc. cit.*, note 278, 850 : « [S]e départir par convention des droits qui dérivent de l'autorité parentale est également contraire à l'ordre public et une délégation complète et définitive de l'autorité parentale est également contraire à l'ordre public. » L'auteure renvoie à *Stevenson* c. *Florant*, [1925] R.C.S. 532. Voir également Jean-Louis BAUDOUIN, *Les obligations*, 3e éd., Cowansville (Qc), Yvon Blais, 1989, pp. 83-84.

Il va sans dire que, malgré la nullité de l'entente, rien n'empêche les parties de donner effet au contrat lorsque la femme porteuse ne s'oppose pas à la remise de l'enfant[308]. Signalons toutefois que c'est l'application des règles de la filiation du droit civil et de la common law qui rend possible ce résultat[309].

Puisque le droit actuel n'interdit pas la maternité de substitution et la tolère même indirectement, la question est de savoir s'il convient de modifier cette situation. Dans l'affirmative, il s'agirait de légiférer, soit pour légaliser le contrat de maternité de substitution et en régir les modalités, soit au contraire pour le prohiber expressément parce que contraire à l'ordre public.

> Ce n'est pas [...] parce que la culture et le droit de la famille traditionnel se trouvent bouleversés par l'hypothèse des mères de substitution que ce bouleversement doit nécessairement être vu comme négatif et être restreint ou prohibé. Le fait impose un choix de confirmation ou d'infirmation du droit positif.[310]

2. La commercialité

La dimension pécuniaire de la maternité de substitution évoque non seulement le danger de l'exploitation des parties mais également celui d'une dérive vers le trafic d'enfants, actuellement prohibé au Canada par la législation sur l'adoption et sur la protection de la jeunesse :

> [TRADUCTION]
> Bien que chacune des provinces canadiennes ait sa propre législation en matière d'adoption, le cadre législatif fondamental reste uniforme partout au pays. La législation pose des restrictions quant à l'adoptant et à l'adopté. Partout en Amérique du Nord, on perçoit une certaine inquiétude à l'égard de ce qu'on appelle le trafic d'enfants, c'est-à-dire le placement d'enfants en vue de l'adoption par des intermédiaires sans scrupules et avides de profits qui, invariablement, se soucient très peu du bien-être de l'enfant. C'est pourquoi la législation restreint l'exercice de la fonction d'intermédiaire et ses modalités. Notamment, la perception d'une rémunération pour le placement d'un enfant ou la prestation de tout autre service en matière d'adoption est rigoureusement réglementée[311].

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308. CRDO, *op. cit.*, note 2, pp. 99-100 :

> [TRADUCTION]
> Bien qu'on ne puisse s'autoriser du droit des contrats pour forcer l'exécution d'une entente de maternité de substitution, le régime actuel est ainsi conçu qu'il n'est pas entièrement impossible aux parties à l'entente de réaliser leur intention. Il existe en effet certaines façons de procéder pour que l'enfant, au moment de sa mise au monde par une femme porteuse ou immédiatement avant, soit confié « naturellement » aux soins et à la garde des parents sociaux, à tout le moins lorsque le père social est aussi le père biologique. Dans cette hypothèse, la question importante n'est plus la validité ni le caractère exécutoire du contrat, mais bien les mesures qui peuvent être prises actuellement lorsqu'un enfant naît ou est sur le point de naître d'une femme porteuse qui est disposée à le remettre aux parents sociaux.

Voir aussi J.-L. BAUDOUIN et C. LABRUSSE-RIOU, *op. cit.*, note 214, pp. 127-128 ; M. RIVET, *loc. cit.*, note 278, 850-851, sur l'utilisation des règles en matière d'adoption au Québec.

309. Voir *infra*, p. 76 et suiv.

310. J.-L. BAUDOUIN et C. LABRUSSE-RIOU, *op. cit.*, note 214, p. 120.

311. Nicholas BALA, Heino LILLES et George THOMSON, *Canadian Children's Law*, Toronto, Butterworths, 1982, pp. 284-285.

À titre d'exemple, voici ce que prévoit le paragraphe 33(2) du *The Adoption Act* de la Saskatchewan :

> [TRADUCTION]
> (2) Sauf dans la mesure permise par la présente loi ou les règlements, il est interdit :
> *a*) de verser ou de toucher,
> *b*) de convenir de verser ou de toucher,
> quelque paiement, récompense ou contrepartie, directement ou indirectement, à quelque fin liée à l'adoption d'un enfant[312].

Puisqu'il est illégal de recevoir un paiement pour avoir contribué à l'adoption d'un enfant, il est possible que, en matière de maternité de substitution, le remboursement des frais à la femme porteuse qui consent à l'adoption de son enfant tombe aussi sous le coup de cette prohibition[313].

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312. *The Adoption Act*, S.S. 1989-90, ch. A-5.1 ; au Québec, voir la *Loi sur la protection de la jeunesse*, précitée, note 284, art. 135.1 :

> Que le placement ou l'adoption ait lieu au Québec ou ailleurs et qu'il s'agisse d'un enfant domicilié au Québec ou non, quiconque
>
> *a*) donne ou reçoit ou accepte de donner ou de recevoir, directement ou indirectement, un paiement ou un avantage, soit pour procurer un placement ou contribuer à un placement en vue d'adoption, soit pour obtenir l'adoption d'un enfant ; [...]
>
> commet une infraction et est passible, sur poursuite sommaire, en outre du paiement des frais, d'une amende de 2 000 $ à 5 000 $, s'il s'agit d'un individu, et d'une amende de 5 000 $ à 10 000 $, s'il s'agit d'une corporation.

Cette disposition n'invalide toutefois pas l'acte accompli. Voir également : *Child Welfare Act*, S.A. 1984, ch. C-8.1, art. 71, mod. par S.A. 1988, ch. 15, art. 35 ; *Loi sur les services à la famille* (N.-B.), précitée, note 286, art. 95 ; *Loi sur les services à l'enfant et à la famille*, L.M. 1985-86, ch. 8, art. 63, 84 ; *The Adoption of Children Act, 1972*, S.N. 1972, n° 36, art. 5, mod. par S.N. 1974, n° 9, art. 3 et S.N. 1979, ch. 35, ann. A, item 1 ; *Loi sur la protection de l'enfance*, L.R.T.N.-O. 1988, ch. C-6, art. 108 ; *Children and Family Services Act*, S.N.S. 1990, ch. 5, art. 69(3) ; *Adoption Act*, R.S.P.E.I. 1988, ch. A-4, art. 23 ; *Children's Act* (Yuk.), précité, note 201, art. 102. L'Ontario et la Colombie-Britannique autorisent certains paiements dans certaines circonstances : voir la *Loi de 1984 sur les services à l'enfance et à la famille*, L.O. 1984, ch. 55, art. 159-160, mod. par L.O. 1987, ch. 4, art. 8 et L.O. 1989, ch. 72, art. 20, et *Adoption Act*, R.S.B.C. 1979, ch. 4, mod. par S.B.C. 1980, ch. 36, art. 2. Dans *Re Adoption Act* (1982), 27 R.F.L. (2e) 72, 75, la Cour suprême de la Colombie-Britannique a permis le remboursement à la mère naturelle de dépenses raisonnables reliées à l'adoption de son enfant par le couple adoptif. Le juge Huddart a toutefois fait le commentaire suivant : [TRADUCTION] « En d'autres occasions et dans d'autres circonstances, d'autres juges pourraient appliquer d'autres critères mais, en l'espèce, les parents adoptifs m'ont convaincu que les critères que j'ai décidé d'appliquer pour approuver le versement d'un paiement à la mère naturelle avaient été remplis. »

313. B.M. DICKENS, *loc. cit.*, note 222, 71 : [TRADUCTION] « Dans les cas où, au Canada, des personnes ont participé ouvertement à de telles ententes, elles n'ont pas été poursuivies, notamment pour avoir violé les dispositions interdisant d'offrir ou de recevoir une somme d'argent en contrepartie d'un consentement à l'adoption. » À titre d'information, voir les décisions américaines *Baby M*, précitée, note 305 ; *Doe* c. *Kelley*, 307 N.W. 2d 438 (1981), *certiorari* refusé, 459 U.S. 1183 (1983) ; *Baby Girl*, 9 Fam. L. Rep. 2348 (1983), où le juge Mudd a refusé de reconnaître l'adoption d'un enfant né d'une femme porteuse par le père génétique et sa femme. Voir aussi *Syrkowski* c. *Appleyard*, Civ. Action 81, 122 D.P. (1981), conf. par 333 N.W. 2d 90 (1983) : [TRADUCTION] « La Cour d'appel, sous la plume du juge Cynar, a jugé que le *Paternity Act* ne s'appliquait pas à l'enfant né à l'issue d'une opération commerciale mettant en cause une femme porteuse. » Cependant, voir à l'effet contraire *In the Matter of Adoption of Baby Girl L.J.*, 505 N.Y.S. 2d 813 (1986), et *Surrogate Parenting Associates* c. *Commonwealth of Kentucky, ex rel Armstrong*, 704 S.W. 2d 209 (1986) ; R. Alta CHARO, « Legislative Approaches to Surrogate Motherhood » (1988), 16:1-2 *Law Med. Health Care* 96, 97.

Signalons toutefois que, sauf au Manitoba[314], les lois provinciales sur l'adoption visent uniquement l'opération qui a pour but l'adoption de l'enfant. Toute autre opération qui ne constitue pas une adoption échapperait donc à leur application.

Du côté du droit criminel, il n'y a actuellement aucune disposition qui prohibe spécifiquement le trafic d'enfants. Et les situations de maternité de substitution ne se prêtent pas toutes au dépôt d'accusations en vertu du paragraphe 279(1) (enlèvement) et des articles 279.1 (prise d'otage), 280 (enlèvement d'une personne âgée de moins de 16 ans), 281 (enlèvement d'une personne âgée de moins de 14 ans), 282 (enlèvement en contravention avec une ordonnance de garde) et 283 (enlèvement en l'absence d'une ordonnance de garde) du *Code criminel*[315].

B. L'enfant

1. La filiation juridique

Nous avons déjà évoqué les problèmes que la procréation médicalement assistée pose au droit de la filiation[316]. Il nous faut maintenant considérer le problème particulier de la filiation de l'enfant né d'une femme porteuse.

La filiation de l'enfant né d'une femme porteuse dépend de différents facteurs : la femme remet ou non l'enfant volontairement ; elle est mariée ou célibataire ; elle fournit l'ovule ou ne fait que porter l'enfant[317].

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314. Le Manitoba ne restreint pas la portée de l'infraction à l'adoption ; la *Loi sur les services à l'enfant et à la famille*, précitée, note 312, prévoit ce qui suit à l'art. 84 :

> Est coupable d'un (sic) infraction punissable sur déclaration sommaire de culpabilité et passible d'une amende de 1 000 $ à 10 000 $ ou d'une peine d'emprisonnement d'au plus 6 mois, ou de ces deux peines, quiconque donne, reçoit ou consent à donner ou à recevoir, directement ou indirectement, une somme d'argent ou une récompense en contrepartie de
>
> *a*) la vente présumée d'un enfant à quelque fin que ce soit ; ou
>
> *b*) l'obtention ou de l'aide à l'obtention de la vente présumée d'un enfant à quelque fin que ce soit.

315. La Conférence sur l'uniformisation des lois au Canada soulève les diverses difficultés auxquelles se heurtent ces dispositions en matière de maternité de substitution. Voir « Trafic d'enfants », dans CONFÉRENCE SUR L'UNIFORMISATION DES LOIS AU CANADA, *Proceedings of the Seventy-second Annual Meeting Held at Saint John, New Brunswick, August, 1990*, Frédéricton (N.-B.), la Conférence, 1991, p. 341.

316. *Supra*, p. 63 et suiv.

317. Voir Jacqueline RUBELLIN-DEVICHI, « Les procréations assistées : état des questions » (1987), 86:3 *Rev. trim. dr. civ.* 457, 489 et suiv.

Dans l'hypothèse où la femme porteuse célibataire remet l'enfant à la naissance, la maternité légale lui sera attribuée mais elle pourra consentir à l'adoption par la conjointe du père[318]. Si elle refuse son consentement, elle pourrait en théorie, à la demande des parents sociaux, être déchue de l'autorité parentale pour avoir abandonné l'enfant.

Si la femme porteuse célibataire refuse de rendre l'enfant, le père social, s'il est aussi le père biologique de l'enfant, pourra faire la preuve de sa paternité[319]. Il devra également faire une demande de garde aux tribunaux qui statueront en fonction de l'intérêt véritable de l'enfant[320].

S'il n'y a pas de conflit (l'enfant est remis) mais que la femme porteuse soit mariée, son mari est présumé être le père de l'enfant[321]. La procédure indiquée est alors le

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318. Voir M. RIVET, *loc. cit.*, note 278, 850-852. Voir aussi la décision récente *Re Ontario Birth Registration number 88-05-045846*, C. Prov. Ontario n° A012/89, 12 février 1990, j. Walmsley. Dans cette décision, le juge a approuvé l'adoption d'un enfant dont la mère avait été inséminée artificiellement avec le sperme de son beau-père à la suite d'une entente de maternité de substitution.

319. B.M. DICKENS, *loc. cit.*, note 222, 68 :

> [TRADUCTION]
> Il arrive qu'un donneur [...] ait l'intention bien arrêtée d'élever l'enfant né d'une femme porteuse ayant agi en application d'une entente de maternité de substitution. [...] Ce genre d'attentes expose le donneur à des frustrations, parfois très arbitraires, en raison de dispositions législatives conçues sans aucun égard aux différentes techniques de procréation et d'insémination artificielles. Dans *The Nova Scotia Family Maintenance Act*, par exemple, le « père éventuel » est défini comme celui qui « a eu des rapports sexuels avec [...] la mère de l'enfant » ; est donc exclu le donneur qui participe à un traitement de procréation hors sexe.

Voir aussi l'art. 589 C.c.Q.

320. *Canadian Family Law Guide*, *op. cit.*, note 277, p. 2461 : [TRADUCTION] « La jurisprudence en matière de garde d'enfants illégitimes fait ressortir le conflit qui oppose, d'une part, le principe de common law qui reconnaît à la mère, sauf preuve contraire, le droit à la garde de son enfant illégitime et le principe d'*equity* qui fait de l'intérêt de ce dernier la considération primordiale. » Voir aussi p. 2470 où l'on cite la décision *D.(W.)* c. *P.(G.)*, [1984] 5 W.W.R. 289 (C.A. Alb.) :

> [TRADUCTION]
> La règle traditionnelle veut que le père naturel d'un enfant né hors du mariage soit réputé n'avoir aucun lien avec l'enfant. Dans ces conditions, il n'est pas admis à en revendiquer la garde à moins de démontrer que la mère l'a abandonné ou négligé, ou d'offrir quelque autre raison grave ou déterminante. Bien entendu, il s'agit là d'une règle élaborée par les tribunaux qui, en tant que telle, pourrait être modifiée de la même façon.

321. B.M. DICKENS, *loc. cit.*, note 222, 69-70 : [TRADUCTION] « Le donneur de sperme qui cherche à établir sa paternité pourrait faire face à des difficultés d'ordre juridique, en particulier si son but est de revendiquer le droit à la garde d'un enfant né en application d'un contrat de maternité de substitution conclu avec une femme mariée. » B.M. KNOPPERS et E. SLOSS, *loc. cit.*, note 272, 716 : [TRADUCTION] « Pour ce qui concerne l'enfant né à la suite d'une insémination artificielle [...], la présomption de paternité pourrait tourner au désavantage du père biologique dans les cas où la femme porteuse est mariée ou cohabite avec un autre homme. »

désaveu de la part du mari de la femme porteuse ou la contestation de paternité[322]. Le père biologique pourra par la suite réclamer sa paternité[323].

Si la femme porteuse mariée refuse de rendre l'enfant à la naissance, le père social devra, avant que la possession d'état ne vienne confirmer le titre du mari, contester la paternité présumée de celui-ci afin d'établir la sienne par la preuve de la filiation biologique.

Même si la femme porteuse n'est pas génétiquement liée à l'enfant, elle sera probablement, en cas de conflit, considérée comme la mère légale. Toutefois, nous pouvons nous demander s'il est possible à la mère génétique d'opposer à la femme porteuse la filiation génétique, de contester la maternité et de présenter une action en réclamation de

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322. Pour le Québec, voir l'art. 581 C.c.Q., sous réserve de l'application des fins de non-recevoir de l'art. 586 C.c.Q. aux autres techniques de procréation médicalement assistée que l'insémination artificielle. Signalons que l'art. 580 du projet de loi 125, précité, note 200, élimine cette ambiguïté. Pour le Yukon et Terre-Neuve, voir *supra*, note 280. Voir B.M. KNOPPERS, *loc. cit.*, note 287, 220. Dans les provinces de common law, la présomption de paternité étant réfragable, une contestation de paternité pourra être entreprise à la condition que la preuve soit suffisamment claire et convaincante. À cet effet, voir *Canadian Family Law Guide*, *op. cit.*, note 277, p. 2401, par. 4305, qui nous informe de ce qui suit :

> [TRADUCTION]
> Le droit attache un poids important à la présomption qui veut que l'enfant né à l'intérieur du mariage soit l'enfant légitime du mari et de la femme. Dès lors que le mari a eu la possibilité de féconder sa femme, le simple déni de sa paternité ne suffit pas à combattre la présomption (*Re Johnston and Johnston* (1975), 10 O.R. (2e) 249 (C. prov.) ; *Guevara* c. *Guevara* (1976), 28 R.F.L. 30 (B.R. Man.)) ; il en va de même de l'aveu de paternité de la part d'un autre homme (*Re Brown and Argue*, [1925] 3 D.L.R. 873 (C.A. Ont.) ; *Re Anderson*, [1947] 3 D.L.R. 302 (C.A. N.-B.)). Par contre, dans *Gray* c. *Foster* (1974), 19 R.F.L. 12 (C. prov. Ont.), on a jugé que l'aveu de paternité d'un autre homme, considéré conjointement avec le fait que celui-ci avait temporairement fourni des aliments à l'enfant et cohabité avec la mère, suffisait à combattre la présomption.

Voir aussi *B. (B.J.)* c. *K. (J.)*, précité, note 277, 151 :

> [TRADUCTION]
> La présomption peut être combattue par une preuve susceptible de convaincre le tribunal que, suivant la prépondérance des probabilités, la mère de l'enfant et son mari n'ont pas eu de rapports sexuels au cours desquels l'enfant aurait pu être conçu. Les résultats du test d'antigènes d'histocompatibilité (typage HLA) auraient dû être pris en considération, de même que toute autre preuve pertinente, au moment de déterminer si l'intimé s'est acquitté de la charge de la preuve. La valeur probante qu'il convient d'accorder aux résultats de ces analyses dépend de la crédibilité des parties.

323. Au Québec, voir l'art. 589 C.c.Q. Pour les provinces de common law, voir B.M. DICKENS, *loc. cit.*, note 282, 355 :

> [TRADUCTION]
> Dans le cadre d'une entente de maternité de substitution où la femme porteuse est mariée, il peut être nécessaire d'inscrire le nom de son mari comme père de l'enfant, à charge pour le père véritable d'obtenir une déclaration judiciaire de paternité avant de pouvoir revendiquer la garde de l'enfant. Il pourrait aussi être tenu d'adopter son propre enfant pour qu'un certificat de naissance l'identifiant comme père puisse être délivré.

B.M. DICKENS, *loc. cit.*, note 222, 70 : [TRADUCTION] « Contrairement à la donneuse d'ovule, l'homme qui conclut une entente et donne son sperme en vue de l'insémination est en droit de revendiquer la paternité de l'enfant ».

maternité[324]. Compte tenu du fait que la règle voulant que l'accouchement fasse preuve de la maternité n'est pas une règle de fond mais une règle de preuve[325] — elle n'apparaît dans aucun texte —, et par analogie avec l'établissement de la paternité[326], d'aucuns prétendent en effet qu'il serait possible d'arguer de la filiation génétique pour combattre la présomption de maternité[327].

Ce bref survol des différentes hypothèses possibles met en lumière l'insuffisance des règles actuelles[328].

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324. Voir à ce sujet, Martine NOLIN et Hélène GUAY, « Le phénomène des femmes porteuses : le droit à l'écoute de la science et de la société », dans Martine NOLIN (dir.), *Réflexions juridiques sur le phénomène des femmes porteuses d'enfants*, Cowansville, (Qc), Yvon Blais, 1986, p. 54 ; voir aussi J. RUBELLIN-DEVICHI, *loc. cit.*, note 317, 488.

325. Monique BANDRAC, « Réflexions sur la maternité », dans *Mélanges offerts à Pierre Raynaud*, Paris, Dalloz-Sirey, 1985, p. 27, à la page 30, « s'il en résulte assurément que la preuve de l'accouchement est de nature à établir la maternité, il n'en résulte aucunement que ce fait soit l'essence même du lien, et l'on ne saurait sérieusement soutenir que les rédacteurs du Code civil aient entendu trancher en réglant la preuve comme ils l'ont fait, un problème de fond dont ils n'avaient pas la moindre idée. »

326. *Id.*, pp. 30-31 :

> Il ressort de la nécessité qui s'impose à l'interprète d'adopter à l'égard du père et la mère une même conception de l'élément biologique dont le rôle est aujourd'hui prépondérant dans les composants de la filiation charnelle. [...] Dès lors que la paternité trouve dans l'hérédité son fondement principal, l'idée paraît s'imposer que c'est aussi l'hérédité, c'est-à-dire la fourniture d'une cellule souche, qui fonde biologiquement et principalement la filiation maternelle.

327. B.M. KNOPPERS et E. SLOSS, *loc. cit.*, note 272, 716 :

> [TRADUCTION]
> Si la mère gestatrice refuse de renoncer à la garde de l'enfant, elle est, en droit, présumée y avoir droit, sous réserve de la preuve ultérieure de la paternité. Dans le cas où l'enfant aurait été conçu in vitro au moyen des gamètes des parents sociaux, ceux-ci n'auraient de recours contre la femme porteuse que dans la mesure où ils seraient à même de faire la preuve des liens génétiques qui les unissent à l'enfant.

Cependant, cette situation n'est pas à l'abri des présomptions irréfragables de paternité, dans les cas où l'insémination artificielle est utilisée, si ces dispositions s'appliquent aux femmes porteuses ; voir, *supra*, note 280. Mis en face de la séparation de la maternité génétique et de la maternité gestatrice, un tribunal du Michigan a reconnu aux parents génétiques le droit de faire inscrire leur nom sur le certificat de naissance et d'être reconnus comme parents légaux. *Smith* c. *Jones*, C. circuit Michigan, n° 8553201460 (14 mars 1986), discuté dans Sherrill COHEN et Nadine TAUB (dir.), *Reproductive Laws for the 1990s*, Clifton (N.J.), Humana, 1989, p. 383. Au sujet d'une décision américaine très récente, on trouve le commentaire suivant :

> [TRADUCTION]
> [U]ne femme porteuse s'est vu refuser le droit de se faire inscrire comme troisième parent d'un enfant conçu in vitro qu'elle a porté pour un couple infertile.
>
> Le juge Richard Parslow de la Cour supérieure des États-Unis a jugé [...] que Anna Johnson ne pouvait prétendre à aucun droit parental sur le petit garçon âgé maintenant d'un mois, et a accordé la garde permanente à Mark et Crispina Calvert, le couple qui a versé 10 000 $ U.S. à M^me^ Johnson pour qu'elle porte l'embryon à terme. [...]
>
> Malgré sa contribution, a dit le juge, « la femme qui porte pour un couple un enfant génétiquement lié à celui-ci n'acquiert aucun droit parental. »

Murray CAMPBELL, « Woman Loses Bid to Be Parent », *The* [*Toronto*] *Globe and Mail* (23 octobre 1990) A-14. Cette décision a été confirmée par *Anna J.* c. *Mark C.*, 286 Cal. Rptr. 369 (1991).

328. La Conférence sur l'uniformisation des lois au Canada, dans sa loi modifiant la loi uniforme sur le statut de l'enfant, précitée, note 203, a adopté les modifications suivantes :

2. La garde de l'enfant

De la filiation découle l'autorité parentale[329] et, de celle-ci, la garde de l'enfant.

En matière de procréation médicalement assistée, si la filiation est établie en faveur de la femme porteuse et de son mari, ils auront droit à la garde de l'enfant à moins qu'ils ne soient déchus de leur autorité parentale[330] ou qu'il ne soit dans l'intérêt de l'enfant que la garde de celui-ci leur soit retirée[331].

D'autre part, si la filiation juridique est établie en faveur de la femme porteuse et du père social, la question de la garde de l'enfant peut devenir épineuse. Le critère est

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[TRADUCTION]
11.3 La femme qui donne naissance à un enfant avant ou après l'entrée en vigueur du présent article est réputée être la mère de l'enfant, peu importe que celui-ci soit issu d'un de ses ovules ou non.

11.4 (1) La femme qui fournit un ovule en vue d'une conception assistée mais qui ne donne pas naissance à l'enfant issu de cet ovule est réputée ne pas en être la mère.

329. M. D.-CASTELLI, *op. cit.*, note 274, p. 182.

330. Pour obtenir la déchéance de l'autorité parentale, il faut prouver, d'une part que son titulaire a « commis, par action ou abstention, un manquement grave et injustifié à son devoir de parent » (*C. (G.)* c. *V.-F. (T.)*, [1987], 2 R.C.S. 244, 246) et, d'autre part, que cette déchéance est dans l'intérêt de l'enfant (voir art. 654 C.c.Q. et l'art. 606 du projet de loi 125, précité, note 200) ; B.M. DICKENS, *loc. cit.*, note 222, 71-72.

331. En common law, voir B.M. DICKENS, *loc. cit.*, note 222, 52 :

[TRADUCTION]
Dans la plupart des cas [...], on considère que l'État a pour mission de réaliser l'intérêt véritable de l'enfant, tel qu'il est déterminé au cours du processus judiciaire. Dans ce conflit qui oppose les [...] deux principes [les « droits naturels » des parents et l'intérêt véritable de l'enfant], il semble bien accepté, au Canada et dans les autres pays de common law, que l'« intérêt véritable » de l'enfant doit prévaloir.

Voir aussi M. Joyce SCHLOSSER, « Third Party Child-Centred Disputes: Parental Rights v. Best Interest of the Child » (1984), 22 *Alta L. Rev.* 394, 398, 401. En droit civil, voir M. D.-CASTELLI, *op. cit.*, note 274, p. 185. Celle-ci renvoie à la décision de la Cour suprême dans *C. (G.)* c. *V.-F. (T.)*, précitée, note 330, où le caractère primordial de l'intérêt de l'enfant a été confirmé. Dans cette décision, la garde a été accordée à des tiers, compte tenu de l'intérêt des enfants, mais sans qu'il y ait déchéance de l'autorité parentale, ni perte du droit de garde. M. le juge Beetz, à la p. 267, a fait le commentaire suivant : « Dans une telle situation, le titulaire est privé de l'exercice de la garde, mais il n'est pas déchu du droit lui-même. »

alors celui de l'intérêt de l'enfant[332] ou « intérêt véritable de l'enfant[333] », qui doit être apprécié dans chaque cas à la lumière des circonstances de l'espèce[334].

Le parent qui n'obtient pas la garde reste quand même titulaire de l'autorité parentale mais, dans les faits, l'exercice de celle-ci risque d'être réduit à un simple droit de surveillance[335]. Certes, il pourra éventuellement bénéficier d'un droit de visite et de sortie, mais ce droit n'est pas automatique.

Somme toute, deux possibilités s'offrent au législateur : soit résoudre le problème de la garde de l'enfant en accordant une valeur juridique aux ententes privées entre la femme porteuse et les parents sociaux, soit laisser l'intérêt de l'enfant déterminer le sort du litige.

En conclusion, ce sont les aspects contractuel et commercial de la maternité de substitution, ainsi que la filiation et la garde de l'enfant, qui font problème. Nous reprendrons l'analyse de ces questions au chapitre des recommandations.

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332. M. D.-Castelli, *op. cit.*, note 274, p. 186. Voir l'art. 30 C.c. et les art. 33 et 34 du projet de loi 125, précité, note 200. Voir également la *Loi de 1985 sur le divorce*, S.C. 1986, ch. 4. Pour la détermination de l'intérêt de l'enfant, voir *id.*, les par. 16(8), 16 (10) et 17(9). Voir B.M. Dickens, *loc. cit.*, note 222, 72. Cet auteur cite l'observation du juge Dubin dans *Re Moores and Feldstein* (1973), 38 D.L.R. (3e) 641, 647 (C.A. Ont.) : [Traduction] « Je ne crois pas qu'il soit prudent de tenir pour acquis que l'enfant recevra davantage d'amour et de compréhension s'il est remis à une femme qui n'en voulait pas au moment de sa naissance que s'il est laissé aux soins affectueux de ceux qui l'ont voulu depuis le départ. » Le professeur Dickens déclare à son tour :

> [Traduction]
> De même, il serait odieux et éventuellement néfaste à l'intérêt véritable de l'enfant de remettre celui-ci à des étrangers alors qu'il n'a pas été prouvé que le père n'a pas su respecter les normes minimales de protection de l'enfant prévues par la loi. [...] En Ontario, [...] le paragraphe 55(1) du *Family Law Reform Act* [devenu le par. 56 (1) de la *Loi de 1986 sur le droit de la famille*, précitée, note 200] dispose que : « le tribunal peut, lorsqu'il règle une question relative [...] à un droit de garde ou de visite, passer outre à une disposition d'un contrat familial qui a trait à cette question s'il est d'avis que cette mesure est dans l'intérêt véritable de l'enfant. » Cette disposition consacre la position de la common law et s'applique, en théorie, au litige concernant la garde de l'enfant né dans le cadre d'un contrat de maternité de substitution.

Dans *Clark* c. *Clark* (1952), O.W.N. 671, 671-672 (H.C.), le juge Barlow exprime cette position en ces termes : [Traduction] « L'entente concernant la garde ne lie pas le tribunal si celui-ci, dans l'exercice de son pouvoir discrétionnaire, est d'avis que ses dispositions ne sont pas dans l'intérêt véritable du bien-être physique, moral, affectif et spirituel de l'enfant. » Voir aussi le rapport de la CRDO, *op. cit.*, note 2, pp. 96-97 ; rappelons également la décision américaine *Baby M*, précitée, note 305.

333. En common law, l'expression anglaise *child's best interests* a été rendue en français par le terme « intérêt véritable de l'enfant » ; voir notamment la *Loi de 1986 sur le droit de la famille* de l'Ontario, précitée, note 200.

334. Voir B.M. Dickens, *loc. cit.*, note 222, 53 : [Traduction] « Le concept d'"intérêt véritable" en est venu à s'interpréter comme "la solution la moins préjudiciable". »

335. Voir M. D.-Castelli, *op. cit.*, note 274, pp. 190-191.

III. La *Charte canadienne des droits et libertés*

Afin de compléter cette étude des interrogations du droit canadien, il convient d'examiner l'incidence de la *Charte canadienne des droits et libertés* sur la réglementation par l'État du recours et de l'accès à la procréatique[336].

Nous verrons d'abord la question de savoir si le droit à la liberté ou à la sécurité de la personne, garanti par l'article7 de la Charte, emporte le droit de procréer et si celui-ci comprend le droit de recourir à la fécondation in vitro ou à l'insémination artificielle, ou encore le droit à l'exécution du contrat de maternité de substitution. Nous aborderons ensuite l'article 15 de la Charte et nous étudierons l'incidence des droits à l'égalité sur l'éventuelle intervention de l'État visant à limiter l'accès aux techniques de procréation médicalement assistée. En conclusion, nous ferons quelques brèves remarques sur l'article premier de la Charte.

Mais tout d'abord, il convient de souligner qu'en l'absence de réglementation ou d'autre forme d'intervention du législateur, les questions soulevées par la procréation médicalement assistée ne relèvent pas du droit constitutionnel. Aux termes de l'article 32, la Charte s'applique « au Parlement et au gouvernement du Canada », et « à la législature et au gouvernement de chaque province » ; elle ne régit pas directement l'activité des particuliers[337]. Par conséquent, l'activité des médecins, des hôpitaux ou autres personnes physiques ou morales privées n'est assujettie aux dispositions de la Charte que dans la mesure où les pratiques ou lignes de conduite qu'ils suivent sont dictées par l'État[338].

La décision de l'État de ne pas réglementer les techniques de procréation médicalement assistée est donc inattaquable sur le plan constitutionnel[339]. En revanche, la décision de réglementer l'accès aux techniques de procréation médicalement assistée et leur utilisation fait entrer en jeu les dispositions de la Charte et ouvre la voie aux contestations. Ainsi, la limitation par le législateur de l'accès à ces techniques peut notamment contrevenir à l'article 7 ou à l'article 15 de la Charte.

A. L'article 7 : le droit à la vie, à la liberté et à la sécurité de la personne

L'article 7 est libellé comme suit : « *Chacun* a droit à la vie, à la liberté et à la sécurité de sa personne ; il ne peut être porté atteinte à ce droit qu'en conformité avec les principes de justice fondamentale » [mis en italique par nos soins].

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336. La question du partage constitutionnel des pouvoirs législatifs dans ce domaine ne sera pas abordée ici.

337. *SDGMR* c. *Dolphin Delivery Ltd.*, [1986] 2 R.C.S. 573.

338. Voir *McKinney* c. *Université de Guelph*, [1990] 3 R.C.S. 229 ; *Harrison* c. *Université de la Colombie-Britannique*, [1990] 3 R.C.S. 251 ; *Douglas/Kwantlen Faculty Assn.* c. *Douglas College*, [1990] 3 R.C.S. 570 ; *Stoffman* c. *Vancouver General Hospital*, [1990] 3 R.C.S. 483.

339. Bien entendu, la limitation, par des personnes ou des organismes privés, de l'accès aux techniques de procréation médicalement assistée pourrait faire l'objet de plaintes en vertu des textes provinciaux sur les droits de la personne si elle équivaut à de la discrimination fondée sur le sexe, la situation familiale, la situation matrimoniale ou l'orientation sexuelle.

La coupure causée par le point-virgule qui sépare cette phrase (ainsi que l'emploi du mot « and » dans la version anglaise) laisse entendre que l'article pourrait être interprété de façon disjonctive, et ainsi garantir, d'une part, le « droit à la vie, à la liberté et à la sécurité de sa personne » et, d'autre part, le droit à ce qu'il ne soit « porté atteinte à ce droit qu'en conformité avec les principes de justice fondamentale. » Les tribunaux ont toutefois rejeté cette interprétation, estimant que l'article 7 garantissait un seul droit qui protège contre les atteintes au droit à la vie, à la liberté et à la sécurité de la personne, sauf dans la mesure où ces atteintes sont conformes aux principes de justice fondamentale[340]. L'établissement d'une violation de l'article 7 comporte donc deux étapes. En premier lieu, il faut établir qu'il y a eu atteinte à sa vie, à sa liberté ou à la sécurité de sa personne[341] et, en second lieu, que cette atteinte est contraire aux principes de justice fondamentale.

Le mot « chacun » soulève pour sa part la question de savoir si l'enfant à naître est visé et s'il peut de ce fait invoquer un droit à la vie auquel il ne pourrait être porté atteinte qu'en conformité avec les principes de justice fondamentale. Si l'enfant à naître jouit effectivement des droits garantis par l'article 7, ou s'il s'agit d'une « personne » pour l'application de l'article 15, la Charte pourrait avoir des répercussions, par exemple, sur le sort des embryons congelés destinés à la fécondation in vitro.

Avant l'adoption de la Charte, le droit canadien reconnaissait l'existence juridique du fœtus seulement lorsqu'il sortait vivant du sein de sa mère[342]. Les tribunaux qui ont examiné la question sous le régime de la Charte ont repris la position traditionnelle de la common law en déclarant que l'enfant à naître ne pouvait invoquer les droits garantis par la Charte[343]. Cette position est conforme au droit américain[344], au droit britannique[345]

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340. Voir *Singh* c. *Ministre de l'Emploi et de l'Immigration*, [1985] 1 R.C.S. 177 ; *R.* c. *Jones*, [1986] 2 R.C.S. 284 ; *R.* c. *Morgentaler*, [1988] 1 R.C.S. 30.

341. Suivant la jurisprudence, les trois intérêts protégés par l'article 7 — la vie, la liberté et la sécurité de la personne — sont indépendants et doivent donc être interprétés séparément. Voir l'affaire *Singh*, précitée, note 340, 204-205 ; *Renvoi relatif au paragraphe 94(2) de la* Motor Vehicle Act *(C.-B.)*, [1985] 2 R.C.S. 486, 500 ; *R.* c. *Morgentaler*, précité, note 340, 52.

342. Voir *Montreal Tramways Company* c. *Léveillé*, [1933] R.C.S. 456 ; *Duval* c. *Seguin* (1972), 26 D.L.R. (3e) 418 (H.C. Ont.) ; *Dehler* c. *Ottawa Civic Hospital* (1979), 25 O.R. (2e) 748 (H.C.), conf. par (1980) 29 O.R. (2e) 677 (C.A.), autorisation d'en appeler à la Cour suprême refusée, [1981] 1 R.C.S. viii ; *Langlois* c. *Meunier*, [1973] C.S. 301.

343. *Borowski* c. *Attorney-General for Canada* (1987), 39 D.L.R. (4e) 731 (C.A. Sask.) ; *Campbell* c. *Attorney-General of Ontario* (1987), 58 O.R. (2e) 209 (H.C.), conf. par (1987) 60 O.R. (2e) 617 (C.A.), autorisation d'en appeler à la Cour suprême refusée, [1987] 1 R.C.S. vi. Mais voir la décision rendue récemment par la Cour d'appel du Québec dans l'affaire *Daigle*, précitée, note 223 ; la Cour a décidé, à trois juges contre deux, que le fœtus jouissait du droit à la vie en application de la Charte québécoise, précitée, note 258. Cependant, cette décision a été infirmée par un arrêt unanime de la Cour suprême du Canada.

344. Voir *Roe* c. *Wade*, 410 U.S. 113, 161 (1973) : [TRADUCTION] « [L]e droit répugne à adhérer à toute théorie voulant que la vie, telle que nous la connaissons, commence avant la naissance, ou à conférer des droits juridiques à l'enfant à naître, sauf dans des cas strictement définis et lorsque les droits sont subordonnés à la naissance d'un enfant vivant ». Toutefois, dans un arrêt récent, *Webster* c. *Reproductive Health Services*, 492 U.S. 490, 518, 526 (1989), la majorité des juges a déclaré que le jugement *Roe* pourrait être infirmé dans un avenir prochain. Quatre des juges ont exprimé l'avis que l'arrêt *Roe* [TRADUCTION] « était mal fondé sur le plan théorique et inapplicable en pratique ». Le juge O'Connor a laissé entendre que la Cour devrait [TRADUCTION] « réexaminer l'arrêt *Roe* [. . .] très attentivement » dans une affaire ultérieure.

345. *Paton* c. *Trustees of BPAS*, [1978] 2 All E R 987, 989 (B.R.) : [TRADUCTION] « En droit anglais, le fœtus ne peut, à mon avis, exercer aucun droit personnel, du moins pas avant d'être né et d'avoir une existence distincte de celle de sa mère. »

et à la *Convention de sauvegarde des droits de l'homme et des libertés fondamentales*[346]. En revanche, la Constitution de l'Irlande protège de façon expresse le droit à la vie de l'enfant à naître[347], et les tribunaux de l'Allemagne de l'Ouest ont jugé qu'un fœtus bénéficiait de la garantie constitutionnelle du droit à la vie[348].

La Cour suprême du Canada a récemment refusé de trancher cette question dans l'affaire *Borowski* c. *Canada (procureur général)*[349], estimant que la question n'avait en l'espèce qu'un intérêt théorique et que l'appelant n'avait plus qualité pour poursuivre l'action[350]. En dépit de cette incertitude, il semble peu probable que la position anglo-canadienne traditionnelle à l'égard des droits de l'enfant à naître fléchisse sous le régime de la Charte[351]. Par conséquent, nous posons ici la prémisse que le régime juridique applicable au fœtus ou à l'embryon n'est assujetti à aucune contrainte découlant du statut constitutionnel de l'enfant à naître.

1. Le droit de procréer

Le droit à la vie, à la liberté et à la sécurité de la personne emporte-t-il le droit de procréer ? Assurément, la vie d'une personne n'est pas menacée parce que celle-ci se voit refuser l'accès aux techniques de procréation médicalement assistée. Tout au plus cette personne se trouve-t-elle privée de la possibilité de créer une nouvelle vie ; le droit à la vie n'est donc aucunement en cause ici. En revanche, il est permis de croire que le droit de recourir aux moyens susceptibles de favoriser la procréation constitue un élément du droit à la liberté ou du droit à la sécurité de la personne.

Le sens de l'expression « droit à la liberté » n'a pas encore été précisé par la Cour suprême du Canada. À tout le moins, nous savons qu'elle vise les atteintes à la

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346. Aussi appellée la *Convention européenne des droits de l'homme* (1955), 213 R.T.N.U. 223. *Paton* c. *United Kingdom* (1980), 3 E.H.R.R. 408 : le fœtus ne jouit pas du droit à la vie en vertu de l'article 2 de la Convention, du moins pendant les premiers stades de la grossesse.

347. L'article 40.3.3., inséré dans la Constitution de l'Irlande à la suite d'un référendum tenu en 1983, dispose que [TRADUCTION] « L'État reconnaît à l'enfant à naître le droit à la vie et, compte tenu du droit à la vie également reconnu à la mère, s'engage à le respecter dans ses lois et, dans la mesure du possible, à le défendre ».

348. Voir la discussion dans le jugement *Borowski* (1987), précité, note 343, 747-748.

349. [1989] 1 R.C.S. 342.

350. L'affaire *Borowski* (1989), précitée, note 349, a commencé par une contestation de l'art. 251 du *Code criminel*, l'ancienne disposition relative à l'avortement thérapeutique. Or, en janvier 1988, la Cour suprême a rendu sa décision dans l'affaire *Morgentaler*, précitée, note 340, dans laquelle l'art. 251 a été invalidé parce qu'il portait atteinte aux droits de la femme garantis par l'art. 7 de la Charte. En conséquence, lorsque la Cour suprême a été saisie de l'affaire *Borowski*, plus tard au cours de l'année, le fondement juridique de la contestation n'existait plus.

351. Pour une discussion complète des nombreuses difficultés juridiques et éthiques soulevées par ce point de vue, voir Catherine TOLTON, « Medicolegal Implications of Constitutional Status for the Unborn: "Ambulatory Chalices" or "Priorities and Aspirations" » (1988), 47 *U.T. Fac. L. Rev.* 1.

liberté de mouvement, comme l'emprisonnement[352]. Mais outre les cas de contrainte physique, elle « peut avoir plusieurs sens », comme la Cour suprême l'a elle-même fait remarquer[353]. Pourtant, jusqu'ici, seule la juge Wilson a étudié dans ses jugements la portée éventuelle de la « liberté » protégée par l'article 7 ; les autres juges n'ont pas encore trouvé l'occasion de le faire. Par exemple, dans l'arrêt *R.* c. *Jones*[354], le juge La Forest s'est montré disposé à tenir pour acquis que le droit à la liberté englobait le « droit des parents d'éduquer leurs enfants comme ils l'entendent », mais il n'a pas jugé nécessaire de trancher la question.

La juge Wilson a pour sa part élaboré une définition du droit à la liberté qui comporterait le droit de procréer. Selon elle, « le droit à la liberté énoncé à l'art. 7 garantit à chaque individu une marge d'autonomie personnelle sur ses décisions importantes touchant intimement à sa vie privée[355]. » Dans l'arrêt *Jones*[356], elle a déclaré que le droit à la liberté protégeait le droit du père ou de la mère d'éduquer ses enfants conformément à ses croyances religieuses. Elle a en outre jugé, dans l'affaire *Morgentaler*[357], que la décision d'une femme d'interrompre ou non une grossesse appartenait à la catégorie des décisions protégées contre l'ingérence de l'État par le droit à la liberté. Une telle décision entraîne « des conséquences psychologiques, économiques et sociales profondes pour la femme enceinte[358]. » Or, ne pourrait-on en dire autant de la décision de recourir à la procréatique pour mettre un enfant au monde ?

La définition de la liberté établie par la juge Wilson repose largement sur une jurisprudence constitutionnelle américaine qui reconnaît l'existence d'un domaine d'autonomie personnelle en matière de procréation, lequel fait partie de la liberté garantie par la disposition relative à l'application régulière de la loi du Quatorzième amendement. Par exemple, dans les arrêts *Singh*[359] et *Jones*[360], elle se réclame d'un passage du jugement *Meyer* c. *Nebraska*[361], dans lequel la Cour suprême des États-Unis déclare ce

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352. Voir *Renvoi relatif au paragraphe 94(2) de la* Motor Vehicle Act *(C.-B.)*, précité, note 341.

353. Voir l'affaire *Singh*, précitée, note 340, 206.

354. Précité, note 340, 302.

355. *R.* c. *Morgentaler*, précité, note 340, 171. Voir également l'arrêt *Jones*, précité, note 340, 318, dans lequel la juge Wilson tient le raisonnement suivant à l'égard du droit à la liberté :

> Je crois que les rédacteurs de la Constitution en garantissant la « liberté » en tant que valeur fondamentale d'une société libre et démocratique, avaient à l'esprit la liberté pour l'individu de se développer et de réaliser son potentiel au maximum, d'établir son propre plan de vie, en accord avec sa personnalité ; de faire ses propres choix, pour le meilleur ou pour le pire, d'être non conformiste, original et même excentrique, d'être, en langage courant, « lui-même » et d'être responsable en tant que tel.

356. Précité, note 340.

357. Précitée, note 340.

358. *Id.*, 171.

359. Précité, note 340, 205.

360. Précité, note 340, 317-318.

361. 262 U.S. 390 (1923).

qui suit: [TRADUCTION] « [La liberté] s'entend sans aucun doute non seulement de l'absence de contrainte physique mais également du droit des individus [...] de se marier, de fonder un foyer et d'élever des enfants[362]. »

Dans l'arrêt *Morgentaler*[363], la juge Wilson a souscrit à la jurisprudence américaine — que nous examinerons ci-dessous — qui a établi que le droit à la liberté garanti par le Quatorzième amendement emportait le droit à la contraception et à l'avortement. La position de la juge Wilson se résume ainsi : toute ingérence de l'État dans le recours aux moyens de procréer porterait atteinte à la liberté. Reste à savoir si une définition aussi large de la liberté ralliera la majorité de la Cour.

Le droit à la sécurité de la personne, comme le droit à la liberté, peut avoir plusieurs sens[364]. Pour reprendre les termes du juge en chef Dickson dans l'arrêt *Morgentaler*, l'essence de ce concept est que « le corps humain doit être protégé des ingérences de tiers[365]. » Dans l'arrêt *Singh*, la juge Wilson a déclaré que la sécurité de la personne protégeait tout autant l'individu contre la menace d'un châtiment corporel ou de souffrances physiques, que contre le châtiment lui-même[366]. Et les tribunaux ont laissé entendre que le droit à la sécurité de la personne englobait à la fois le droit au bien-être psychologique et le droit à l'intégrité physique[367]. Comme l'a soutenu le juge Lamer dans le jugement *Mills* c. *La Reine*[368] :

> [L]a notion de sécurité de la personne ne se limite pas à l'intégrité physique ; elle englobe aussi celle de protection contre « un assujettissement trop long aux vexations et aux vicissitudes d'une accusation criminelle pendante ». [...] Celles-ci comprennent la stigmatisation de l'accusé, l'atteinte à la vie privée, la tension et l'angoisse résultant d'une multitude de facteurs, y compris éventuellement les perturbations de la vie familiale, sociale et professionnelle, les frais de justice et l'incertitude face à l'issue et face à la peine[369].

Dans l'arrêt *Morgentaler*, les cinq juges majoritaires ont décidé que, en faisant subir à la femme une tension psychologique grave, l'État portait atteinte à la sécurité de sa personne. Le juge Beetz a déclaré que la sécurité de la personne « inclu[ait] le droit au traitement médical d'un état dangereux pour la vie ou la santé, sans menace de répression pénale[370]. » Le juge en chef Dickson, pour sa part, s'est exprimé ainsi :

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362. *Id.*, 399.

363. Précité, note 340, 167-171.

364. *Singh*, précité, note 340, 206.

365. Précité, note 340, 53.

366. Précité, note 340, 207.

367. *R.* c. *Videoflicks Ltd* (1984), 48 O.R. (2e) 395, 433 (C.A.).

368. [1986] 1 R.C.S. 863.

369. *Id.*, 919-920.

370. Précité, note 340, 81.

> L'atteinte que l'État porte à l'intégrité corporelle et la tension psychologique grave causée par l'État, du moins dans le contexte du droit criminel, constituent une atteinte à la sécurité de la personne. Il n'est pas nécessaire en l'espèce de se demander si le droit va plus loin et protège les intérêts primordiaux de l'autonomie personnelle, tel le droit à la vie privée ou des intérêts sans lien avec la justice criminelle[371].

Il se peut que l'anxiété et la tension psychologique causées à la personne incapable de procréer naturellement qui se voit refuser l'accès à la procréatique soient visées par la définition de la sécurité de la personne formulée dans l'arrêt *Morgentaler*. Cependant, comme l'a fait remarquer le juge en chef Dickson, la composante psychologique de la sécurité de la personne n'a pas encore été interprétée par la Cour suprême en dehors du contexte des poursuites criminelles.

La Cour ne s'est pas encore prononcée non plus sur la question de savoir si la sécurité de la personne dépassait la protection de l'intégrité physique ou psychologique, de sorte qu'elle engloberait un droit plus large au respect de la vie privée ou de l'autonomie, lequel pourrait comporter le droit de procréer et d'autres droits liés à la vie familiale. Certains tribunaux inférieurs ont toutefois laissé entendre que la sécurité de la personne embrassait bel et bien le droit à l'autonomie dans la prise de décisions personnelles[372].

Compte tenu de l'imprécision qui entoure les termes « liberté » et « sécurité de la personne », alors que les dispositions de la Charte commencent à peine à être examinées par les tribunaux, il n'est pas inutile d'examiner le droit constitutionnel américain dans la mesure où il se rapporte au droit de procréer. Comme nous l'avons souligné ci-dessus, la juge Wilson a jugé opportun de s'y référer pour interpréter l'article 7 de la Charte et, en l'absence d'arrêt de principe canadien, la jurisprudence américaine continuera d'influer sur l'interprétation de la Charte.

La Cour suprême des États-Unis a d'abord reconnu l'importance de l'autonomie génésique dans le jugement *Skinner* c. *Oklahoma*[373], en affirmant que la stérilisation forcée des repris de justice portait atteinte à la disposition garantissant le droit à une protection égale de la loi. Le juge Douglas a qualifié le droit d'avoir des enfants [TRADUCTION] « de domaine délicat et important des droits de la personne [. . .] un droit essentiel à la perpétuation de la race humaine[374] ». Plus loin dans son jugement, il ajoute ce qui suit :

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371. *Id.*, 56.

372. Voir *Re T and Catholic Children's Aid Society* (1984), 46 O.R. (2e) 347 (C.P.) : le droit à la sécurité de la personne comprend le droit au respect de la vie privée ou de l'autonomie familiale ; *S. (S.)* c. *Director of Child and Family Services*, [1987] 5 W.W.R. 309 (B.R. Man.) : les conclusions du tribunal vont dans le même sens ; *R.L. Crain Inc.* c. *Couture* (1983), 6 D.L.R. (4e) 478, 502 (B.R. Sask.) : [TRADUCTION] « [L]'expression "sécurité de la personne" comprend le droit au respect de la dignité de la personne et le droit au respect de l'intimité ou d'un domaine d'autonomie personnelle sur lequel l'État ne doit pas empiéter de façon arbitraire ou injustifiée. »

373. 316 U.S. 535 (1942).

374. *Id.*, 536.

[TRADUCTION]
Il s'agit en l'espèce d'un texte de loi concernant un des droits civils fondamentaux de l'homme. Le mariage et la procréation sont essentiels à l'existence et à la survie même de la race [...] [La personne dont l'État a ordonné la stérilisation] est à jamais privée de cette liberté fondamentale[375].

La plupart des tribunaux américains qui ont reconnu un droit à l'autonomie génésique ont invoqué le droit au respect de la vie privée garanti par le Quatorzième amendement. Bien que la Constitution des États-Unis ne reconnaisse pas de façon explicite le droit au respect de la vie privée, la Cour suprême a jugé que l'un des aspects de la liberté garantie par les dispositions relatives à l'application régulière de la loi du Quatorzième amendement consiste dans [TRADUCTION] « le droit au respect de sa vie privée ou d'un certain domaine intime[376] ». Or, ce droit au respect de la vie privée comprendrait [TRADUCTION] « le droit de prendre librement certaines décisions importantes[377] », comme la liberté de recourir à la contraception pour éviter une maternité non désirée[378]. Le juge Brennan s'est exprimé en ces termes :

[TRADUCTION]
Si le droit au respect de la vie privée doit avoir quelque sens, c'est le droit pour l'individu, marié ou célibataire, d'être protégé contre toute ingérence injustifiée de l'État dans des questions aussi intimement liées à la personne que la décision de porter ou d'engendrer un enfant[379].

La Cour suprême des États-Unis a également conclu que le droit de se marier et celui d'élever et d'éduquer des enfants étaient des droits fondamentaux garantis par le Quatorzième amendement[380]. De même, en 1973, la Cour suprême a estimé que le droit au respect de la vie privée, mis en lumière par la jurisprudence, était [TRADUCTION] « suffisamment large pour englober la décision d'une femme d'interrompre ou non sa grossesse[381]. »

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375. *Id.*, 541.

376. *Roe* c. *Wade*, précité, note 344, 152.

377. *Whalen* c. *Roe*, 429 U.S. 589, 599-600 (1977).

378. *Griswold* c. *Connecticut*, 381 U.S. 479 (1965) (l'État ne peut criminaliser le recours à la contraception par des personnes mariées) ; *Eisenstadt* c. *Baird*, 405 U.S. 438 (1972) (annulation d'un règlement rendant les moyens de contraception moins accessibles aux célibataires qu'aux couples mariés) ; *Carey* c. *Population Services International*, 431 U.S. 678, 687 (1977) (annulation d'une interdiction placée par l'État sur la distribution commerciale des moyens de contraception non médicaux) : [TRADUCTION] « À la lumière des arrêts qui ont suivi, il ressort de l'affaire *Griswold* que la Constitution protège contre l'immixtion injustifiée de l'État les décisions prises par un individu en ce qui concerne la procréation. »

379. *Eisenstadt* c. *Baird*, précité, note 378, 453.

380. *Loving* c. *Virginia*, 388 U.S. 1 (1967) (la race ne peut servir de motif pour limiter le droit d'un individu de se marier) ; *Zablocki* c. *Redhail*, 434 U.S. 374 (1978) (annulation d'une loi exigeant qu'une certaine catégorie de résidents de l'État obtiennent une autorisation judiciaire pour se marier) ; *Meyer* c. *Nebraska*, précité, note 361, 399 (reconnaissance du droit constitutionnel de [TRADUCTION] « se marier, fonder un foyer et élever des enfants ») ; *Pierce* c. *Society of Sisters*, 268 U.S. 510 (1925) (éducation des enfants).

381. *Roe* c. *Wade*, précité, note 344, 170. Voir également *Planned Parenthood of Missouri* c. *Danforth*, 428 U.S. 52 (1976) ; *Akron (City of)* c. *Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983) ; *Thornburgh* c. *American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986).

Toutefois, la Cour a reconnu à l'État le pouvoir, d'une part, de refuser d'assumer le coût des avortements[382], même s'ils sont nécessaires pour préserver la vie ou la santé de la mère[383], et d'autre part, d'interdire cette pratique aux professionnels de la santé et aux hôpitaux qui relèvent de sa compétence[384].

Le droit au respect de la vie privée en droit constitutionnel américain protège donc l'individu contre toute atteinte de l'État à la réalisation de son potentiel procréateur. En outre, l'individu a le droit de recourir aux moyens de contraception sans intervention de l'État. Cependant, l'État n'est pas tenu de fournir à l'individu les ressources nécessaires pour avoir accès aux moyens de contraception.

Le droit au respect de la vie privée s'étend-il au droit de recourir, sans ingérence de l'État, aux techniques de procréation médicalement assistée existantes ? Les tribunaux américains n'ont pas encore tranché cette question. Cependant, une certaine doctrine soutient que le droit d'une personne au respect de sa vie privée englobe celui d'avoir accès sans restriction aux moyens susceptibles de lui permettre de procréer[385]. Selon Robertson, le plus ardent défenseur de ce point de vue, la réglementation par l'État des conditions d'accès à la procréatique doit être justifiée par un objectif public impératif: [TRADUCTION] « l'État doit s'acquitter du fardeau de prouver le préjudice réel causé par l'utilisation de ces techniques[386] ». Mais, comme le fait observer Knoppers, la consécration par les tribunaux du droit constitutionnel de procréer par tous les moyens disponibles, lequel serait l'expression de la liberté personnelle ou du droit à la vie privée, est problématique[387], surtout compte tenu de l'actuelle hésitation de la Cour suprême des États-Unis à élargir les règles de cet aspect substantiel de l'application régulière de la loi[388].

Si l'on peut dire que la dimension constitutionnelle de cette question est empreinte d'incertitude aux États-Unis, cela est encore plus vrai au Canada où les tribunaux commencent à peine à interpréter les dispositions de la Charte. Jusqu'ici, l'existence d'un droit de procréer garanti par l'article 7 n'a été avancée qu'une fois devant les tribunaux canadiens. Dans l'affaire *E. (M^me^)* c. *Eve*[389], il s'agissait de savoir si un tribunal avait le pouvoir, en vertu de sa compétence *parens patriae*, d'autoriser la stérilisation non thérapeutique d'une femme atteinte de déficience mentale. La Cour suprême du Canada a conclu ce qui suit :

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382. *Maher* c. *Roe*, 432 U.S. 464 (1977).

383. *Harris* c. *McRae*, 448 U.S. 297 (1980).

384. *Webster* c. *Reproductive Health Services*, précité, note 344.

385. Voir les articles de John A. ROBERTSON : « Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth » (1983), 69 *Va. L. Rev.* 405 ; « Embryos, Families, and Procreative Liberty: The Legal Structure of the New Reproduction » (1986), 59 *S. Cal. L. Rev.* 939 ; « Decisional Authority over Embryos and Control of IVF Technology » (1988), 28:3 *Jurimetrics* 285. Voir aussi Barbara KRITCHEVSKY, « The Unmarried Woman's Right to Artificial Insemination: A Call for an Expanded Definition of Family » (1981), 4 *Harv. Women's L.J.* 1 ; Andrea E. STUMPF, « Redefining Mother: A Legal Matrix for New Reproductive Technologies » (1986), 96 *Yale L.J.* 187.

386. John A. ROBERTSON, « Procreative Liberty and the State's Burden of Proof in Regulating Noncoital Reproduction » (1988), 16:1-2 *Law Med. Health Care* 18, 24.

387. B.M. KNOPPERS, *loc. cit.*, note 225, 348-349.

388. Voir *Bowers* c. *Hardwick*, 478 U.S. 186 (1986).

389. [1986] 2 R.C.S. 388.

> La comparaison entre la grave atteinte au droit d'une personne et le préjudice physique certain qui découle d'une stérilisation non thérapeutique sans consentement, et les avantages très douteux qui peuvent en résulter, m'a persuadé qu'on ne peut jamais déterminer d'une manière certaine qu'un tel acte médical est à l'avantage de cette personne. Par conséquent, l'acte médical ne devrait jamais être autorisé à des fins non thérapeutiques en vertu de la compétence *parens patriae*[390].

Se réclamant d'un précédent américain, la partie qui cherchait à obtenir l'autorisation de procéder à la stérilisation a soutenu que l'article 7 comportait le droit à la liberté de choix en matière de procréation, et notamment le droit de choisir d'avoir ou non des enfants et d'exercer ce choix au moyen de la contraception[391]. Le juge La Forest, s'exprimant au nom de la Cour, n'a pas jugé utile de statuer sur la question :

> [S]i l'on présume pour l'instant que la liberté visée dans l'art. 7 protège des droits de ce genre (une question que je m'abstiens d'examiner), l'argument de l'avocat me semble aller plus loin que le genre de protection que devait accorder l'art. 7. Tout ce que l'art. 7 fait, c'est de donner un recours pour protéger les gens contre les lois ou d'autres actions de l'État qui les privent de leur liberté. Il ne s'applique pas en l'espèce[392].

Bien que la Cour n'ait pas jugé nécessaire d'étayer sa décision par les dispositions de la Charte, elle a néanmoins souligné à plusieurs reprises la nature fondamentale du droit de procréer. Le juge La Forest a insisté sur la « reconnaissance juridique croissante du caractère fondamental du droit de procréer[393] », « le grand privilège de procréer[394] » et « [l]'importance du maintien de l'intégrité physique d'un être humain [. . .] particulièrement en ce qui a trait au privilège de procréer[395]. » Il a qualifié la stérilisation envisagée de « grave atteinte au droit d'une personne[396] » et « [d']atteinte irréversible et grave des (sic) droits fondamentaux d'une personne[397] ».

En conclusion, les tribunaux canadiens n'ont pas encore tranché la question de savoir si le droit à la liberté ou le droit à la sécurité de la personne garantis par l'article 7 emportent le droit de procréer. Cependant, à la lumière de la définition large donnée au mot « liberté »

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390. *Id.*, 431.

391. *Id.*, 436.

392. *Ibid.*

393. *Id.*, 419-420.

394. *Id.*, 428.

395. *Id.*, 434.

396. *Id.*, 431.

397. *Id.*, 432. Les tribunaux anglais ont statué dans le même sens dans une affaire analogue. Dans *Re D (a minor)*, [1976] 1 All E R 326, 332, la Cour a déclaré ce qui suit :

> [Traduction]
>
> Le type d'intervention envisagé entraîne la violation d'un droit fondamental de la personne, savoir le droit pour une femme d'avoir des enfants. Par conséquent, l'intervention pratiquée sur une femme pour des raisons non thérapeutiques et sans son consentement porterait atteinte à ce droit.

par la juge Wilson, de l'influence de la jurisprudence américaine et de la conviction avec laquelle le juge La Forest a souligné, dans l'affaire *Eve*, l'importance pour l'individu de pouvoir procréer, on peut s'attendre à ce que, saisie de la question dans une affaire prochaine, la Cour suprême conclue à l'inclusion du droit de procréer dans le droit à la liberté ou à la sécurité de la personne.

2. L'atteinte au droit à la liberté et à la sécurité de la personne et les principes de justice fondamentale

Comme nous l'avons fait remarquer précédemment, la preuve d'une violation de l'article 7 est un processus qui comporte deux étapes. Il faut en premier lieu prouver l'atteinte à la vie, à la liberté ou à la sécurité de la personne et, en second lieu, montrer que l'atteinte n'est pas conforme aux principes de justice fondamentale. Ainsi, dans l'hypothèse où les tribunaux concluraient que le droit à la liberté ou à la sécurité de la personne emporte celui de procréer, la législation limitant l'accès à la procréatique ne porterait pas nécessairement atteinte à l'article 7 ; encore faudrait-il pour cela que les limites législatives en cause aient été imposées en contravention aux principes de justice fondamentale.

Les principes de justice fondamentale visent à la fois la procédure et le fond[398]. Sur le plan processuel, les principes de justice fondamentale s'apparentent aux notions d'équité procédurale de la common law. Pour reprendre les termes de la juge Wilson dans l'arrêt *Singh*, l'équité procédurale signifie que :

> [. . .] le tribunal appelé à se prononcer sur [les] droits [d'une personne] doit agir équitablement, de bonne foi, sans préjugé et avec sérénité, et [. . .] il doit donner à l'accusé l'occasion d'exposer adéquatement sa cause[399].

C'est dire que tout texte de loi limitant l'accès aux techniques de procréation médicalement assistée doit être empreint d'équité procédurale à l'endroit des personnes désireuses de recourir à ces techniques pour exercer leur droit de procréer. Le fonctionnement du régime administratif ne doit pas être inéquitable ni arbitraire[400], et les critères d'admissibilité ne doivent pas être vagues[401]. Le requérant dont la demande a été rejetée devrait avoir la possibilité de faire valoir ses droits[402]. Il doit être informé des motifs du refus avant l'audience et, au cours de celle-ci, il doit avoir la possibilité de présenter adéquatement sa cause. Signalons toutefois qu'une audience proprement dite ne sera pas nécessaire dans les cas où la crédibilité n'est pas en jeu. Comme l'a affirmé la juge Wilson dans l'arrêt *Singh* :

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398. *Renvoi relatif au paragraphe 94(2) de la* Motor Vehicle Act *(C.-B.)*, précité, note 341, 497-499.

399. Précité, note 340, 213, citant *Duke* c. *La Reine*, [1972] R.C.S. 917, 923.

400. Voir *Morgentaler*, précité, note 340.

401. *Ibid.*

402. Voir *Singh*, précité, note 340.

> [J]e suis disposée à accepter la prétention [...] selon laquelle les exigences de l'équité en matière de procédure peuvent varier selon les circonstances [...] Il est donc possible qu'une audition devant l'instance décisionnelle ne soit pas requise dans tous les cas où l'on invoque l'art. 7 de la *Charte*. [...]
>
> Je ferai cependant remarquer que, même si les auditions fondées sur des observations écrites sont compatibles avec les principes de justice fondamentale pour certaines fins, elles ne donnent pas satisfaction dans tous les cas. Je pense en particulier que, lorsqu'une question importante de crédibilité est en cause, la justice fondamentale exige que cette question soit tranchée par voie d'audition[403].

Selon la Cour suprême, d'autre part, les aspects substantiels des principes de justice fondamentale : « [...] se trouvent dans les préceptes fondamentaux de notre système juridique. Ils relèvent non pas du domaine de l'ordre public en général, mais du pouvoir inhérent de l'appareil judiciaire en tant que gardien du système judiciaire[404]. »

Or, suivant l'un de ces principes, la personne innocente sur le plan moral ne doit pas être pénalisée. Aussi le texte de loi susceptible de priver de sa liberté une personne innocente sur le plan moral porterait-il atteinte à l'article 7[405].

L'élément substantiel des principes de justice fondamentale donne aux tribunaux le pouvoir de dépasser le simple examen du caractère équitable de l'application de la loi pour apprécier les textes législatifs du point de vue du fond, afin de déterminer s'ils sont conformes « aux préceptes fondamentaux de notre système juridique ». Les tribunaux semblent ainsi appelés à se prononcer sur le bien-fondé de toute politique législative qui porterait atteinte au droit à la vie, à la liberté ou à la sécurité de la personne, mission qu'ils préfèrent laisser au législateur. Par conséquent, on peut s'attendre à ce que les tribunaux fassent preuve de circonspection dans l'application de l'élément substantiel de l'article 7[406]. Jusqu'ici, la Cour suprême n'a formulé aucun principe substantiel de justice fondamentale en dehors du cadre de la procédure pénale.

Tant que la limitation de l'accès à la procréatique n'est pas arbitraire[407], il est peu probable qu'elle soit jugée incompatible avec les principes substantiels de justice fondamentale. La Cour a déclaré que l'élaboration future des principes de justice fondamentale sera fondée sur des « racines historiques[408] » qui « ont émergé, avec le temps, à titre de présomptions de *common law* », « sont exprimé[e]s dans les conventions internationales sur les droits de la personne » ou « ont été reconnu[e]s comme des éléments essentiels d'un système d'administration de la justice fondé sur la foi en "la dignité et la valeur de la personne humaine" et en "la primauté du droit"[409] ». Or, nos traditions juridiques sont impuissantes à fournir les fondements d'un droit illimité de recourir aux moyens nécessaires pour procréer.

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403. *Id.*, 213-214.
404. *Renvoi relatif au paragraphe 94(2) de la* Motor Vehicle Act *(C.-B.)*, précité, note 341, 503.
405. *Ibid.* ; *R.* c. *Vaillancourt*, [1987] 2 R.C.S. 636.
406. Voir les commentaires du juge en chef Dickson dans l'arrêt *Morgentaler*, précité, note 340, 53.
407. Voir, par exemple, *R.* c. *Beare* ; *R.* c. *Higgins*, [1988] 2 R.C.S. 387.
408. *Renvoi relatif au paragraphe 94(2) de la* Motor Vehicle Act *(C.-B.)*, précité, note 341, 513.
409. *Id.*, 503.

B. L'application de l'article 7 à certains aspects de la procréatique

À la lumière de la discussion générale qui précède sur les principes régissant l'interprétation de l'article 7, abordons maintenant des questions plus précises soulevées par la maternité de substitution et l'accès à la procréatique.

1. La force exécutoire du contrat de maternité de substitution

Dans la présente partie, nous examinerons les effets qu'aurait sur les droits garantis à l'article 7 de la Charte, un texte de loi rendant soit exécutoire, soit inexécutoire le contrat de maternité de substitution, ou réglementant les circonstances dans lesquelles les tribunaux pourraient en ordonner l'exécution.

Le seul cas où l'on ait analysé le droit constitutionnel de procréer dans le contexte de l'exécution du contrat de maternité de substitution est l'affaire américaine *Baby M*[410], portée devant les tribunaux en raison des revendications divergentes de la mère et du père biologiques sur la garde d'un enfant conçu dans le cadre d'un tel contrat. Le père biologique, M. Stern, a fait valoir que le droit de procréer emportait le droit à l'exécution du contrat. Reconnaissant au père le droit constitutionnel à la garde de l'enfant, le tribunal inférieur a suivi le raisonnement suivant :

> [TRADUCTION]
> [. . .] si l'individu a le droit de procréer par coït, alors il a le droit d'engendrer un enfant par d'autres méthodes. Si c'est la procréation qui est protégée, alors les moyens de procréer doivent l'être également. Les valeurs et les intérêts sous-tendant la création d'une famille sont les mêmes, quel que soit le moyen grâce auquel la famille a été fondée. Le tribunal est d'avis que le recours à une femme porteuse fait partie des moyens protégés [. . .] On pourrait même soutenir que le refus d'exécuter ces contrats et l'interdiction de verser des sommes d'argent constitueraient une ingérence inconstitutionnelle dans la liberté de procréer, car ils empêcheraient les couples sans enfant de prendre les moyens nécessaires pour fonder une famille [. . .] Une femme et son mari ont le droit de procréer et d'élever une famille. Les moyens d'y parvenir ne peuvent leur être refusés que si un intérêt impératif de l'État est en jeu[411].

Finalement, le tribunal a décidé que les droits des parties sous le régime du contrat étaient protégés par la Constitution. En appel, la Cour suprême du New Jersey a rejeté ce raisonnement :

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410. 525 A. 2d 1128 (N.J. Super. Ch. 1987).

411. *Id.*, 1164-1165. Voir les critiques de ce raisonnement dans Laurence A. TRIBE, *American Constitutional Law*, 2e éd., Mineola (N.Y.), Foundation, 1988, pp. 1360-1362.

[TRADUCTION]
Le droit de procréer est tout simplement le droit d'avoir des enfants naturellement, par la voie de rapports sexuels ou d'insémination artificielle, sans plus. Ce droit de M. Stern n'a pas été violé [...] La garde, les soins à donner, la présence à assurer et l'éducation qui suivent la naissance ne font pas partie du droit de procréer [...] Affirmer que le droit de procréer de M. Stern lui confère le droit de revendiquer la garde de l'enfant reviendrait à dire que le droit de procréer de M^me^ Whitehead ne lui donne *pas* le droit à la garde de son enfant ; ce serait prétendre que le droit de procréer protégé par la Constitution comprend un droit contractuel qui permet de neutraliser le droit de procréer de quelqu'un d'autre [...] Rien dans notre culture ni notre société ne laisse même supposer que le père soit investi d'un droit fondamental à la garde de l'enfant découlant de son droit de procréer lorsque la mère de l'enfant s'y oppose[412].

L'arrêt *Baby M* est conforme à une décision antérieure, *Doe* c. *Kelley*[413], où avait été mise en doute la validité d'une loi du Michigan sur l'adoption qui interdisait le versement d'argent ou d'une autre contrepartie en matière d'adoption ou de procédures connexes. Un couple avait cherché à conclure un contrat de maternité de substitution et à invoquer la procédure d'adoption pour faire reconnaître ses droits sur l'enfant. Le tribunal a jugé que la loi ne portait pas atteinte au droit de procréer du couple :

[TRADUCTION]
La loi en question n'interdit pas directement à John Doe et à Mary Roe d'avoir l'enfant comme prévu. Elle fait plutôt obstacle au paiement par les demandeurs d'une contrepartie dans le cadre de la procédure d'adoption de l'État. Dans les faits, le contrat des demandeurs dénote le désir d'utiliser le code de l'adoption pour modifier le statut juridique de l'enfant, c'est-à-dire ses droits en matière d'aliments, de succession *abintestat*, etc. À notre avis, cet objectif déborde le domaine des intérêts fondamentaux que protège le droit au respect de la vie privée contre l'intervention, même raisonnable, de l'État[414].

Robertson a contesté cette position, suivant laquelle le droit de procréer n'emporterait pas un [TRADUCTION] « droit contractuel garanti par la Constitution qui permet de neutraliser le droit de procréer de quelqu'un d'autre[415] ». Il soutient que les parties à une entente de maternité de substitution devraient être libres de contracter pour aliéner leurs droits constitutionnels comme elles l'entendent :

[TRADUCTION]
Compte tenu de l'autonomie des couples et des femmes porteuses, on peut soutenir sans crainte que le contrat conclu avant la conception par les parties, lequel rend possible l'existence même de l'enfant, devrait à première vue être déterminant, comme s'il s'agissait de donneurs de sperme ou d'ovule. [...] Les raisons pour lesquelles l'accord, s'il a été conclu librement et en connaissance de cause, ne devrait pas prévaloir dans les circonstances sont tout simplement obscures[416].

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412. *Baby M*, précité, note 305, 1253-1254. Voir la critique de cet arrêt dans J.A. ROBERTSON, *loc. cit.*, note 386, 23-24.

413. Précitée, note 313.

414. *Id.*, 441.

415. J.A. ROBERTSON, *loc. cit.*, note 386, 23 ; voir aussi *Baby M*, précité, note 305, 1254.

416. J.A. ROBERTSON, *loc. cit.*, note 386, 23-24.

Dans le contexte canadien, le raisonnement voulant que le père biologique ait le droit, en vertu de l'article 7 de la Charte, de réclamer l'exécution d'un contrat de maternité de substitution dépend d'un certain nombre de prémisses qui font problème. La première est que le droit de procréer emporte des droits de garde après la naissance de l'enfant. Selon la deuxième, refuser au père la garde de l'enfant porterait atteinte aux principes de justice fondamentale. Enfin, la mère biologique serait libre de renoncer par contrat à son propre droit constitutionnel de procréer (dans la mesure où ce droit engloberait aussi le droit à la garde de l'enfant) et ne serait pas admise à revenir sur cette renonciation après la naissance.

D'autre part, la revendication par la mère biologique du droit constitutionnel de conserver la garde de l'enfant conçu dans le cadre d'un contrat de maternité de substitution repose également sur un certain nombre de propositions discutables. En premier lieu, le droit de procréer comprendrait le droit à la garde de l'enfant. En deuxième lieu, refuser à la mère la garde de l'enfant violerait les principes de justice fondamentale. Enfin, le contrat conclu avant la conception et visant la remise de l'enfant constituerait, de la part de la mère, une renonciation inopérante à ses droits constitutionnels.

Pour ce qui est du droit à la garde, on pourrait soutenir que le droit de procréer est illusoire si l'État permet que l'enfant soit enlevé à ses parents dès la naissance[417] ». Cependant, des difficultés évidentes font obstacle à l'imposition d'un cadre constitutionnel pour l'analyse des revendications divergentes des parties dans un litige concernant la garde. Notre droit fait généralement primer l'intérêt véritable de l'enfant sur les droits des parents soi-disant garantis par la Charte. Il n'est donc pas étonnant que les tribunaux se soient montrés réticents à permettre que l'application des dispositions de la Charte viennent ajouter à la complexité procédurale des litiges relatifs à la protection et à la garde des enfants[418].

À supposer que chacun des parents biologiques puisse revendiquer le droit constitutionnel d'obtenir la garde de l'enfant, le problème des revendications contradictoires, comme dans l'affaire *Baby M*[419], reste néanmoins entier. On a soutenu que pour sortir de cette impasse, il suffirait de faire prévaloir le contrat : la demande constitutionnelle du père biologique l'emporterait parce que la mère biologique a renoncé à ses droits constitutionnels en adhérant à l'entente de maternité de substitution[420].

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417. *Id.*, 23 : [TRADUCTION] « Élever un enfant est le résultat qui rend la conception elle-même si digne de protection [. . .] La raison pour laquelle M. Stern a embauché une femme porteuse est précisément pour concevoir un enfant qu'il élèverait ensuite.

418. Voir, *Re T and Catholic Children's Aid Society*, précité, note 372 ; *Re McTavish and Director, Child Welfare Act* (1986), 32 D.L.R. (4e) 394 (B.R. Alb.).

419. Précitée, note 305.

420. Voir J.A. ROBERTSON, *loc. cit.*, note 386.

De fait, la Cour suprême du Canada a jugé que les citoyens étaient libres de renoncer à leurs droits constitutionnels[421]. Elle a déclaré qu'une personne ne saurait être forcée de se prévaloir d'un droit conçu en sa faveur même si ce droit est d'ordre public[422]. Mais, pour être opérante, la renonciation doit être volontaire et « doit se fonder sur une appréciation véritable des conséquences de la renonciation à ce droit[423]. » Cette condition soulève la question de savoir si la mère biologique pourra jamais avoir, au moment de conclure un contrat de maternité de substitution, une « appréciation véritable » des problèmes émotifs auxquels elle devra faire face au moment de rendre l'enfant au père biologique. Autre difficulté : de toute évidence, la femme porteuse qui tente de conserver la garde de l'enfant ne renonce plus *volontairement* à ses droits constitutionnels présumés. Or, il n'est pas certain qu'une renonciation à des droits constitutionnels soit opposable si elle est révoquée par la suite dans ces circonstances.

À l'heure actuelle, le contrat de maternité de substitution est probablement inexécutable tant en droit civil qu'en common law, parce que contraire à l'ordre public[424], bien que la question n'ait pas encore été portée devant les tribunaux canadiens. En Angleterre, le législateur a récemment déclaré inexécutoire le contrat de maternité de substitution et interdit toute entente analogue à titre onéreux[425], conformément aux recommandations contenues dans la plupart des études effectuées dans ce domaine[426]. Comme Knoppers et Sloss le font remarquer :

> [Traduction]
> Ces recommandations visent l'incidence psychologique et émotive néfaste qu'a sur la mère gestatrice l'obligation de donner l'enfant qu'elle a porté, l'aversion qu'inspire la renonciation contractuelle aux droits parentaux et le risque d'une exploitation commerciale de ces accords (que l'un des rapports britanniques a assimilé à la prostitution)[427].

Si le législateur devait intervenir pour déclarer inexécutoire le contrat de maternité de substitution, il est peu probable que les tribunaux y voient une entorse à l'article 7 de la Charte. En effet, à supposer qu'une telle mesure législative soit considérée comme portant atteinte à la liberté, dans la mesure où elle grèverait le droit de procréer des hommes dont les partenaires sont stériles, et à supposer également que les tribunaux reconnaissent à la mère biologique la liberté de renoncer par contrat à ses droits constitutionnels, il reste possible de réglementer la conclusion d'ententes à titre onéreux visant la conception d'un enfant sans pour autant enfreindre les principes de justice fondamentale.

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421. Voir *Clarkson* c. *La Reine*, [1986] 1 R.C.S. 383, 396 (le prévenu ne peut être forcé de se prévaloir du droit à l'assistance d'un avocat) ; *R.* c. *Turpin*, [1989] 1 R.C.S. 1296 (renonciation au droit à un procès devant jury).

422. *R.* c. *Turpin*, précité, note 421, 1316.

423. *Clarkson* c. *La Reine*, précité, note 421, 396.

424. Voir le texte sous la rubrique « La légalité et la légitimité », *supra*, p. 73.

425. Voir *Human Fertilisation and Embryology Act 1990* (R.-U.), 1990, ch. 37, art. 36 et le *Surrogacy Arrangements Act 1985* (R.-U.), 1985, ch. 49, art. 2, lesquels reprennent les recommandations du *Rapport de la Commission d'enquête concernant la fécondation et l'embryologie humaines*, Paris, La Documentation française, 1985, pp. 76-77 (présidente : Dame Mary Warnock) (ci-après Rapport Warnock).

426. Pour plus de détails, voir l'annexe A, *infra*, p. 183.

427. *Loc. cit.*, note 272, 709.

Du reste, deux principes fondamentaux du droit de la famille nous incitent à conclure au caractère inexécutoire du contrat de maternité de substitution. Le premier veut que le droit à la garde de l'enfant soit déterminé en fonction de l'intérêt véritable de celui-ci et non de la volonté contractuelle des parents. C'est précisément la préséance de l'intérêt de l'enfant sur la liberté contractuelle qui sous-tend la législation interdisant aux parties à un contrat de mariage ou à un accord de cohabitation de transiger sur les droits de garde et de visite concernant les enfants[428], et qui permet aux tribunaux de passer outre, lorsque l'intérêt véritable de l'enfant l'exige, à toute disposition d'un contrat familial ayant trait aux aliments dus à cet enfant, à son éducation, à sa formation morale, ou à un droit de garde ou de visite[429]. Deuxièmement, il est illégal d'accepter un paiement en contrepartie de l'accomplissement des formalités entourant l'adoption d'un enfant[430]. Ainsi, loin de violer les principes fondamentaux du système juridique canadien, une telle mesure législative serait en fait conforme à ces principes.

En résumé, le recours aux dispositions de l'article 7 de la Charte pour régler les différends concernant la garde de l'enfant né d'une femme porteuse se heurte à quantité d'obstacles d'ordre juridique. Par conséquent, un texte de loi qui viendrait ou bien consacrer le caractère exécutoire du contrat de maternité de substitution, ou bien le déclarer inexécutoire, risquerait peu d'être attaqué au nom des droits constitutionnels des parents biologiques.

2. La fécondation in vitro

La théorie voulant que le droit de procréer emporte celui de recourir aux techniques de fécondation in vitro a été soutenue devant un tribunal fédéral américain, mais la question n'a pas été tranchée. Dans l'affaire *Smith* c. *Hartigan*[431], un couple infertile a prétendu qu'une loi de l'Illinois rendait illégale la fécondation in vitro et, de ce fait, [TRADUCTION] « portait atteinte au droit au respect de la vie privée parce que la disposition faisait obstacle à la réalisation du seul espoir du couple de concevoir un enfant[432] ». Bien que le procureur général, défendeur dans cette affaire, ait admis que [TRADUCTION] « la situation des demandeurs constituait un plaidoyer fort éloquent en faveur d'un droit fondamental à [la fécondation in vitro][433] », le tribunal a jugé qu'il était inutile de statuer sur la question constitutionnelle, ayant décidé que la loi n'interdisait pas la fécondation in vitro dans les circonstances.

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428. Voir par exemple les al. 52(1)*c*) et 53(1)*c*) de la *Loi de 1986 sur le droit de la famille* de l'Ontario, précitée, note 200.

429. *Id.*, par. 56(1).

430. Voir *supra*, p. 74 et suiv.

431. 556 F. Supp. 157 (1983).

432. *Id.*, 160.

433. *Id.*, 161.

Il est impossible de prédire si les tribunaux canadiens tiendront l'accès aux services de fécondation in vitro pour inclus dans le droit de procréer. La portée de celui-ci pourrait bien être limitée à la procréation naturelle, quitte à y inclure l'insémination artificielle. Quoi qu'il en soit, il semble prudent de poser pour hypothèse que l'accès à la fécondation in vitro pourrait être visé par l'article 7 de la Charte.

Mais même si un tribunal en venait à cette conclusion, cela ne signifie pas que l'accès à la fécondation in vitro ne pourrait pas être restreint ni réglementé. La jurisprudence canadienne donne à penser que les droits et obligations garantis par la Charte ne font aux gouvernements aucune obligation positive d'initier des mesures législatives ou des programmes en la matière, puisque l'application de la Charte suppose au départ une action quelconque de la part de l'État[434]. Celui-ci n'est donc nullement tenu d'assurer d'emblée l'accès aux moyens de fécondation in vitro. En revanche, l'intervention du législateur pour restreindre l'accès aux services existants ferait entrer la Charte en jeu et permettrait à un tribunal de conclure à la violation du droit de procréer des femmes infertiles et de leurs partenaires. Il est donc essentiel que toute mesure de restriction éventuelle soit conforme aux principes de justice fondamentale.

Prévoir les exigences que poseront les tribunaux sur le plan processuel afin d'assurer le respect des principes de justice fondamentale dans ce contexte est une tâche difficile. À tout le moins, il faudra sans doute que l'admissibilité aux services de fécondation in vitro soit déterminée en fonction de critères équitables et rationnels qui auront été communiqués aux candidats. La procédure devra en outre être empreinte d'équité procédurale à l'endroit des personnes qui demandent des services de fécondation in vitro. Celles-ci devront avoir la possibilité de présenter adéquatement les circonstances motivant leur demande. Mais pour peu que les critères soient clairs et que la crédibilité ne soit pas en cause, il serait étonnant qu'un tribunal exige la tenue d'une audience en bonne et due forme à cette étape de la procédure[435]. D'autre part, il est encore plus difficile de prévoir si les principes de justice fondamentale exigeront, dans ce contexte, l'établissement d'un droit d'appel contre la décision refusant l'accès aux services de fécondation in vitro[436].

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434. Voir par exemple *SDGMR* c. *Dolphin Delivery Ltd.*, précité, note 337. Toutefois, dans l'hypothèse où les autorités publiques mettraient sur pied un programme d'application restrictive, les tribunaux pourraient, au nom de la Charte, ordonner que les avantages ou services en cause soient offerts d'une manière qui respecte les droits à l'égalité garantis par l'article 15 ; voir par exemple *Schachter* c. *Canada*, [1988] 3 C.F. 515 (1re inst.), conf. par [1990] 2 C.F. 129 (C.A.). Il est vrai que certaines dispositions de la Charte — comme celles des articles 16 à 23 qui concernent les droits linguistiques — confèrent expressément aux citoyens le droit d'obtenir certains services de l'État, et ce, en l'absence de toute action préalable de la part de celui-ci. Toutefois, ces dispositions n'ont pas d'application ici en ce qui a trait au droit de procréer.

435. Voir l'affaire *Singh*, précitée, note 340.

436. *Ibid.* Dans cette affaire, l'atteinte à la liberté invoquée par les appelants consistait dans la menace de persécution (voire de mort) à laquelle ils s'exposaient en retournant dans leur pays d'origine. La Cour suprême a jugé en l'espèce que les principes de justice fondamentale exigeaient la reconnaissance d'un droit d'appel contre la décision leur refusant le statut de réfugié. À notre avis, toutefois, l'atteinte portée au droit à la liberté de la personne qui se voit refuser l'accès à la fécondation in vitro n'est pas comparable à celle dont il était question dans l'affaire *Singh*. Et comme les exigences de l'art. 7 de la Charte sur le plan processuel varient en fonction de la gravité de l'atteinte portée, les tribunaux pourraient bien conclure que l'établissement d'un droit d'appel n'est pas indispensable dans ce contexte.

3. L'insémination artificielle

Les seules causes publiées ayant trait à l'insémination artificielle portent sur la filiation[437]. Et dans l'unique affaire où ait été soulevée l'inconstitutionnalité d'une éventuelle interdiction du recours à l'insémination artificielle pour les femmes célibataires, la Section du Michigan de l'American Civil Liberties Union a déposé une plainte au nom d'une femme célibataire à laquelle on avait refusé l'insémination artificielle. Cependant, l'affaire s'est réglée lorsque la clinique a accepté la demande de la femme[438].

Contrairement à la fécondation in vitro, l'insémination artificielle est une intervention peu coûteuse, très simple sur le plan technique et qui n'entraîne généralement que peu ou pas de complications médicales. Elle peut même être pratiquée très simplement dans l'intimité de son propre foyer, sans l'intervention d'experts. Et, contrairement à la maternité de substitution, la participation du donneur génétique est de courte durée et souvent réduite au don de sperme. Pour ces motifs, la réglementation de l'insémination artificielle soulève d'importantes questions relatives au droit au respect de la vie privée qui ne se posent pas à l'égard des autres techniques de procréation sans rapports sexuels. Tout comme la réglementation [TRADUCTION] « n'est ni souhaitable ni matériellement possible dans le cas de la procréation naturelle[439] », de même, on peut soutenir que l'État n'a pas sa place dans la chambre à coucher où une femme cherche à pratiquer sur elle-même l'insémination artificielle. Toute mesure visant à réglementer un acte aussi éminemment privé constituerait une atteinte au droit à la liberté et pourrait s'avérer incompatible avec les principes de justice fondamentale. L'un des préceptes de base de notre système juridique est en effet le principe de la non-intervention dans les questions privées qui n'entraînent aucun préjudice pour autrui.

Par ailleurs, la réglementation des banques de sperme et de l'insémination artificielle médicalement assistée ne soulève aucune difficulté en ce qui concerne le droit à la vie privée. Il s'agit seulement ici de veiller à éviter les problèmes d'ordre génétique ou médical. Le fait de garantir la sûreté de l'insémination artificielle de cette manière ne soulèverait aucune objection constitutionnelle.

4. Le droit d'être informé de ses origines biologiques

L'enfant conçu grâce à la procréatique jouit-il d'un droit constitutionnel d'être informé de ses origines génétiques ? Nous examinerons cette question dans la présente partie.

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437. *C.M.* c. *C.C.*, 377 A. 2d 821 (1977) (le donneur dont l'identité est connue a des droits parentaux) ; *Jhordan C.* c. *Mary K.*, 179 Cal. App. 3d 386 (1986) (le donneur est le père de l'enfant).

438. *Snede* c. *Wayne State Univ.*, E.D. Mich., n° 80-725-83, 15 juillet 1980. Pour une description du mémoire de la demanderesse dans cette affaire, voir Patricia A. KERN et Kathleen M. RIDOLFI, « The Fourteenth Amendment's Protection of a Woman's Right to Be a Single Parent through Artificial Insemination by Donor » (1982), 7 *Women's Rights L. Rep.* 251, 254, n. 22.

439. CRDO, *op. cit.*, note 2, p. 154.

Le besoin psychologique de connaître ses racines biologiques est de plus en plus reconnu dans le contexte de l'adoption, et un nombre croissant d'enfants adoptifs exercent des pressions sur les tribunaux et les législateurs pour qu'ils assouplissent la politique de confidentialité traditionnellement appliquée par les organismes d'adoption[440]. Selon des recherches récentes, la divulgation de ce type de renseignements à l'adopté devenu adulte est souhaitable, sous réserve du droit des parents biologiques à la confidentialité de tout renseignement permettant de les identifier. On a recommandé que le droit du père ou de la mère biologique — ou du donneur de matériel génétique — de conserver l'anonymat ait préséance sur le droit de l'enfant d'être informé[441].

Aux États-Unis, c'est sans succès que l'on a fait valoir le droit fondamental de l'enfant adoptif de connaître ses origines biologiques pour contester la constitutionnalité des lois assurant la confidentialité des dossiers d'adoption. En général, les tribunaux ont jugé que ces lois établissaient un équilibre souhaitable entre le droit à la vie privée des parents biologiques, l'intérêt de l'État à protéger l'intégrité du processus d'adoption et le droit de l'adopté à l'information[442].

L'article 7 de la Charte canadienne impose une distinction entre l'information qui permet d'identifier les parents biologiques et celle qui ne le permet pas. La divulgation de renseignements d'ordre médical et génétique non identifiants est souvent nécessaire pour assurer le bien-être physique de l'enfant conçu par procréation médicalement assistée. Dans l'affaire *Morgentaler*[443], les juges majoritaires ont reconnu que le droit à la sécurité de la personne comprenait le droit au traitement médical lorsque l'état du sujet présente un danger pour sa vie ou sa santé. Le refus de divulguer des renseignements nécessaires à la protection de la vie et de la santé porterait pareillement atteinte au droit à la sécurité de la personne conçue grâce à la procréatique. Un texte de loi qui prescrirait la communication automatique de renseignements non identifiants assurerait la protection de l'intérêt de l'enfant, sans porter atteinte au droit du géniteur au respect de sa vie privée.

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440. B.M. KNOPPERS, *loc. cit.*, note 263 ; ONTARIO, MINISTÈRE DES SERVICES SOCIAUX ET COMMUNAUTAIRES, *Nouvelle politique de l'Ontario relativement à la divulgation de renseignements sur l'adoption*, Toronto, Imprimeur de la Reine pour l'Ontario, 1986 ; *Background Paper on the Establishment of an Adult Adoption Disclosure Registry in British Columbia*, Victoria (C.-B.), Ministry of Social Services and Housing, 1986 ; GROUPE DE TRAVAIL COMMUNAUTAIRE SUR LA SANTÉ DE LA MÈRE ET DE L'ENFANT, *Adoption: Acquisition and Disclosure of Records*, Winnipeg (Man.), le Groupe de travail, 1981 ; COMMISSION MANITOBAINE DE RÉFORME DU DROIT, *Working Paper on Confidentiality of Adoption Records*, Winnipeg (Man.), la Commission, 1979 ; BARREAU DU QUÉBEC, *Mémoire du Comité du Barreau du Québec sur la confidentialité des dossiers d'adoption et la recherche des antécédents*, Montréal, le Barreau, 1986 ; Clare MARCUS, *Adopted? A Canadian Guide for Adopted Adults in Search of Their Origins*, Vancouver (C.-B.), International Self-Counsel Press, 1979.

441. Voir B.M. KNOPPERS, *loc. cit.*, note 263.

442. Voir *Alma Society Incorporated* c. *Mellon*, 601 F. 2d 1225 (1979) ; *Re Roger B.*, 84. Ill. 2d 325 (1981) ; Debra D. POULIN, « The Open Adoption Records Movement: Constitutional Cases and Legislative Compromise » (1987-1988), 26 *J. Fam. L.* 395 ; Heidi A. SCHNEIDER, « Adoption Contracts and the Adult Adoptee's Right to Identity » (1988), 6 *Law & Inequality* 185 ; Carolyn BURKE, « The Adult Adoptee's Constitutional Right to Know His Origins » (1975), 48 *S. Cal. L. Rev.* 1196 ; Marilee C. UNRUH, « Adoptee's Equal Protection Rights » (1981), 28 *U.C.L.A. L. Rev.* 1314.

443. Précitée, note 340.

En revanche, la communication de renseignements identifiants soulève manifestement le problème du conflit entre l'intérêt de l'enfant à connaître l'identité de ses géniteurs et l'intérêt du donneur à demeurer anonyme. Bon nombre de donneurs participent à des programmes de conception médicalement assistée à la condition de conserver l'anonymat. Des dispositions prévoyant la divulgation de renseignements qui permettent de les identifier mettraient par conséquent en péril le fonctionnement de ces programmes et porteraient atteinte au droit à la vie privée des donneurs. Compte tenu de ces revendications divergentes, également irrésistibles, un texte de loi qui interdirait la divulgation de renseignements identifiants sans le consentement du donneur serait sans doute conforme à l'article 7 de la Charte[444].

C. L'article 15 : les droits à l'égalité

L'article15 de la Charte dispose notamment :

> 15. (1) La loi ne fait acception de personne et s'applique également à tous, et tous ont droit à la même protection et au même bénéfice de la loi, indépendamment de toute discrimination, notamment des discriminations fondées sur la race, l'origine nationale ou ethnique, la couleur, la religion, le sexe, l'âge ou les déficiences mentales ou physiques.

Récemment, la Cour suprême a établi un cadre pour l'analyse des revendications relatives aux droits à l'égalité dans l'arrêt *Andrews* c. *Law Society of British Columbia*[445]. Le juge McIntyre, s'exprimant au nom de la majorité, a formulé l'objectif de l'article 15 en ces termes :

> [S]elon cet idéal qui est certes impossible à atteindre, une loi destinée à s'appliquer à tous ne devrait pas, en raison de différences personnelles non pertinentes, avoir un effet plus contraignant ou moins favorable sur l'un que sur l'autre[446].

La preuve d'une transgression de l'article15 se fait elle aussi en deux temps. En premier lieu, il faut établir la violation de l'un des quatre droits à l'égalité[447] garantis par l'article 15 et, en second lieu, démontrer que la loi a des effets discriminatoires[448].

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444. Dans la plupart des rapports récents portant sur l'adoption et sur la procréation médicalement assistée, on a recommandé que l'information non identifiante puisse être communiquée sans difficulté et que les renseignements identifiants ne soient communiqués qu'avec le consentement du donneur. Voir B.M. KNOPPERS et E. SLOSS, *loc. cit.*, note 272, 693-696 ; B.M. KNOPPERS, *loc. cit.*, note 263, 832-833 ; ONTARIO, MINISTÈRE DES SERVICES SOCIAUX ET COMMUNAUTAIRES, *op. cit.*, note 440.

445. [1989] 1 R.C.S. 143.

446. *Id.*, 165.

447. Voir l'arrêt *Turpin*, précité, note 421. Le justiciable doit prouver qu'il est victime d'inégalité devant la loi ou dans l'application de celle-ci, ou que la loi a des effets différents sur lui en ce qui concerne la protection ou le bénéfice auxquels il est censé avoir droit.

448. *Andrews* c. *Law Society of British Columbia*, précité, note 445, 182.

La Cour a défini comme suit le « contenu minimal du droit à l'égalité devant la loi » : « La garantie d'égalité devant la loi vise à promouvoir la valeur selon laquelle toutes les personnes sont sujettes aux mêmes exigences et aux mêmes obligations de la loi et nul ne doit subir un désavantage plus grand que les autres en raison du fond ou de l'application de la loi[449]. »

Quant au concept de la discrimination, le juge McIntyre a, dans l'affaire *Andrews*, repris la définition donnée à ce terme dans l'affaire *Action Travail des femmes* :

> [L]a discrimination s'entend des pratiques ou des attitudes qui, de par leur conception ou par voie de conséquence, gênent l'accès des particuliers ou des groupes à des possibilités d'emplois, en raison de caractéristiques qui leur sont prêtées à tort [...]
>
> La question n'est pas de savoir si la discrimination est intentionnelle ou si elle est simplement involontaire, c'est-à-dire découlant du système lui-même. Si des pratiques occasionnent des répercussions néfastes pour certains groupes, c'est une indication qu'elles sont peut-être discriminatoires[450].

Le juge McIntyre propose ensuite la définition suivante :

> [L]a discrimination peut se décrire comme une distinction, intentionnelle ou non, mais fondée sur des motifs relatifs à des caractéristiques personnelles d'un individu ou d'un groupe d'individus, qui a pour effet d'imposer à cet individu ou à ce groupe des fardeaux, des obligations ou des désavantages non imposés à d'autres ou d'empêcher ou de restreindre l'accès aux possibilités, aux bénéfices et aux avantages offerts à d'autres membres de la société. Les distinctions fondées sur des caractéristiques personnelles attribuées à un seul individu en raison de son association avec un groupe sont presque toujours taxées de discriminatoires, alors que celles fondées sur les mérites et capacités d'un individu le sont rarement[451].

Les distinctions établies par la loi ne sont pas nécessairement discriminatoires. La Cour suprême a affirmé très nettement que seules les dispositions législatives ayant des effets inégaux à l'égard de groupes de personnes ayant en commun l'une ou l'autre des caractéristiques énumérées à l'article 15 ou une caractéristique analogue pouvaient être tenues pour discriminatoires au sens de cet article. Une loi qui produirait des inégalités à l'endroit de personnes ne pouvant être rattachées à un groupe visé à l'article 15 ne saurait être considérée comme discriminatoire au sens de cet article. La Cour a souligné que le critère déterminant l'admissibilité d'un groupe de personnes à la protection de l'article 15 consistait dans une situation d'inégalité sociale, politique ou juridique liée à une caractéristique analogue à celles qu'énumère l'article 15. Dans l'arrêt *Andrews*, les juges ont conclu que les personnes qui n'ont pas la citoyenneté constituent un groupe sans pouvoir politique, en butte à une discrimination historique, ce qui en fait un bon exemple de minorité distincte et isolée méritant d'être protégée par l'article 15.

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449. *R.* c. *Turpin*, précité, note 421, 1329.

450. *Andrews* c. *Law Society of British Columbia*, précité, note 445, 174, citation de l'arrêt *Compagnie des chemins de fer nationaux du Canada* c. *Canada (Commission canadienne des droits de la personne)*, [1987] 1 R.C.S. 1114, 1138-1139.

451. *Andrews* c. *Law Society of British Columbia*, précité, note 445, 174-175.

En revanche, dans l'arrêt *Reference Re* Workers' Compensation Act, 1983 (*T.-N.*)[452], la Cour a rejeté de façon sommaire une action attaquant la constitutionnalité d'une loi d'indemnisation des accidents du travail qui empêchait les victimes et les personnes à leur charge de s'adresser aux tribunaux. Tous les juges ont estimé que la loi ne créait aucune discrimination au sens de l'article 15 : « La situation des travailleurs et des personnes à charge en l'espèce n'est aucunement analogue aux situations énumérées au par. 15(1), exigence posée par la majorité dans l'affaire *Andrews* pour permettre le recours au par. 15(1)[453]. »

De même, dans l'affaire *Turpin*[454], des accusés inculpés ailleurs qu'en Alberta contestaient une disposition du *Code criminel* donnant aux personnes inculpées en Alberta seulement le droit de choisir d'être jugées par un juge seul. La juge Wilson, s'exprimant au nom de la Cour, a refusé de conclure au caractère discriminatoire de la disposition, pour le motif que les accusés inculpés ailleurs qu'en Alberta ne pouvaient être considérés comme un « groupe analogue » visé à l'article 15 :

> [...] ce serait tomber dans la fantaisie que de qualifier de « minorité discrète et isolée » les personnes qui, dans toutes les provinces sauf l'Alberta, sont accusées de l'un des crimes énumérés à l'art. 427 du *Code criminel*. [...] Établir une distinction, pour les fins du mode de procès, entre les personnes accusées en Alberta d'infractions énumérées à l'art. 427 et celles qui sont accusées des mêmes infractions ailleurs au Canada ne favoriserait pas, à mon avis, les objets de l'art. 15 en remédiant à la discrimination dont sont victimes les groupes de personnes défavorisées sur les plans social, politique ou juridique dans notre société ou en les protégeant contre toute forme de discrimination. Il serait inutile de chercher des signes de discrimination tel (sic) que des stéréotypes, des désavantages historiques ou de la vulnérabilité à des préjugés politiques ou sociaux en l'espèce parce que ce qui est comparé c'est la situation de personnes qui sont accusées, ailleurs au Canada, d'une des infractions énumérées à l'art. 427, avec celle des personnes ainsi accusées en Alberta. [...] Les personnes qui résident ailleurs qu'en Alberta et qui sont accusées de l'une des infractions énumérées à l'art. 427 hors de l'Alberta ne constituent pas un groupe défavorisé dans la société canadienne au sens de l'art. 15[455].

Il s'ensuit que toute mesure de réglementation concernant l'accès à la procréation médicalement assistée qui créerait des disparités à l'égard de groupes visés à l'article 15 ou de groupes analogues porterait atteinte à cet article. Inversement, une mesure de réglementation qui créerait des disparités à l'égard de groupes qui ne peuvent être assimilés à ceux que vise l'article 15 ne serait pas discriminatoire au sens de cet article. Par exemple, on pourrait difficilement soutenir qu'une règle limitant l'accès à la procréatique est discriminatoire à l'endroit des personnes infertiles en tant que catégorie, celles-ci ne constituant pas une minorité distincte et isolée, victime d'une tradition d'inégalité ou d'impuissance sur le plan politique[456].

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452. [1989] 1 R.C.S. 922.

453. *Id.*, 924.

454. Précitée, note 421.

455. *Id.*, 1333.

456. Il se peut qu'une telle règle impose un fardeau inégal à un sous-groupe des personnes infertiles en fonction de leur sexe, leur classe sociale, leur état matrimonial ou leur orientation sexuelle. Dans ce cas, il serait possible de prouver l'existence d'une discrimination fondée sur un motif énuméré. Pour une analyse de cette question, voir Martha A. FIELD, *Surrogate Motherhood*, éd. augmentée, Cambridge (Mass.), Harvard University Press, 1990, pp. 47-49.

En revanche, une règle à effet discriminatoire ou créant des disparités fondées sur un motif énuméré — tel le sexe ou un autre motif analogue comme l'état matrimonial, l'état parental[457], l'état familial ou l'orientation sexuelle — pourront être attaquées sur la base de l'article 15.

L'état matrimonial est un des exemples les plus nets de motifs de discrimination non énumérés à l'article 15 mais faisant néanmoins l'objet d'une protection constitutionnelle. D'ailleurs, la discrimination fondée sur ce motif est expressément prohibée par la législation sur les droits de la personne en vigueur dans chacune des provinces et chacun des territoires canadiens[458]. En outre, la situation de famille est un motif illicite de discrimination aux termes de la législation fédérale et de celles du Manitoba[459], de l'Ontario[460] et des Territoires du Nord-Ouest[461]. Toute discrimination fondée sur l'état civil d'une personne, qu'elle soit célibataire, mariée, divorcée ou veuve, est interdite. De la jurisprudence qui s'élabore sous le régime de ces garanties législatives des droits de la personne semble émerger le principe qu'une règle ne peut avoir pour fondement des distinctions reposant sur des caractéristiques stéréotypées liées à l'état familial d'un individu, sans tenir compte de sa situation ou de ses compétences véritables en ce qui concerne la prestation ou le service en question[462].

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457. Pour un exemple de discrimination fondée sur l'état parental, voir le jugement *Symes* c. *Canada*, [1989] 3 C.F. 59, 81-82 (1re inst.). Signalons toutefois que cette décision a été infirmée en appel pour d'autres motifs (19 juin 1991), A-290-89 (C.A.).

458. *Loi canadienne sur les droits de la personne*, L.R.C. (1985), ch. H-6 ; *Loi prohibant la discrimination*, L.R.T.N.-O. 1988, ch. F-2 ; *Human Rights Act*, S.Y.T. 1987, ch. 3, al. 6 *k*) ; *Human Rights Act*, S.B.C. 1984, ch. 22 ; *Individual's Rights Protection Act*, R.S.A. 1980, ch. I-2 ; *The Saskatchewan Human Rights Code*, S.S. 1979, ch. S-24.1, par. 12(1) ; *Code des droits de la personne*, L.M. 1987-88, ch. 45 ; *Code des droits de la personne*, L.O. 1981, ch. 53 ; *Charte des droits et libertés de la personne* (Qc), précitée, note 258, art. 10 (« état civil ») ; *Loi sur les droits de la personne*, L.R.N.-B. 1973, ch. H-11 ; *Human Rights Act*, R.S.N.S. 1989, ch. 214 ; *Human Rights Act*, R.S.P.E.I. 1988, ch. H-12 ; *The Human Rights Code*, S.N. 1988, ch. 62. Voir en général A. Anne McLellan, « Marital Status and Equality Rights », dans Anne F. Bayefsky et Mary Eberts (dir.), *Equality Rights and the Canadian Charter of Rights and Freedoms*, Toronto, Carswell, 1985, p. 411.

459. *Code des droits de la personne*, précité, note 458, al. 9(2)*i*).

460. L'Ontario définit l'état familial comme suit : « fait de se trouver dans une relation parent-enfant ». *Code des droits de la personne*, précité, note 458, al. 9(1)*d*).

461. *Loi prohibant la discrimination*, précitée, note 458.

462. *Brossard (ville)* c. *Québec (Commission des droits de la personne)*, [1988] 2 R.C.S. 279, 298 (la politique antinépotisme générale de la municipalité constituait de la discrimination fondée sur l'état civil) ; *Cashin* c. *Société Radio-Canada*, [1988] 3 C.F. 494 (C.A.) ; *Saskatchewan Human Rights Commission* c. *Saskatchewan (Department of Social Services)* (1988), 52 D.L.R. (4e) 253 (C.A. Sask.) (le fait d'accorder des prestations d'aide sociale inférieures aux célibataires constitue de la discrimination fondée sur l'état matrimonial au sens du code des droits de la personne provincial) ; *Schaap* c. *Forces armées canadiennes*, [1989] 3 C.F. 172, 184 (j. Hugessen) (C.A.) : la politique adoptée par l'employeur de ne loger que les couples mariés « s'appuie [. . .] sur un stéréotype qu'il contribue à perpétuer, soit que la valeur sociale de la relation entre un homme et une femme est moins grande lorsqu'elle n'est pas consacrée par le mariage [. . .] C'est un lieu commun d'affirmer que les liens du mariage ne sont pas garants de la permanence ni de la stabilité d'une relation, tout comme leur absence n'est pas nécessairement le signe d'une simple amourette. »

Voir cependant *Canada (Procureur général)* c. *Mossop*, [1990] 1 C.F. 18 (C.A.), inf. *Mossop* c. *Canada (Secrétariat d'État)* (1989), 10 C.H.R.R. D/6064.

En général, on s'accorde pour dire que l'état matrimonial et l'état familial constituent des motifs de discrimination qui devraient être reconnus en application de l'article 15 de la Charte. Par exemple, le Comité parlementaire sur les droits à l'égalité a conclu ce qui suit :

> Selon nous, il convient de lire l'article 15 de la *Charte* dans le contexte de l'évolution historique du statut juridique de la femme mariée en se rappelant que, au niveau tant national qu'international, il est généralement admis que l'État se doit de protéger la cellule conjugale et, bien souvent, la famille. En conséquence, bien que ni l'état matrimonial ni la situation de famille ne soient expressément énoncés dans la liste des motifs de discrimination illicite figurant à l'article 15, on peut affirmer qu'ils sont implicitement couverts par cet article de la *Charte*[463].

Dans la décision *Re MacVicar and Superintendent of Family and Child Services*[464], la Cour a conclu que l'état matrimonial était un motif de discrimination interdit par la Charte : [TRADUCTION] « L'état matrimonial résulte directement de la décision personnelle de se marier ou non, avec l'approbation de l'État, ce qui confère certains droits et impose certaines obligations. [. . .] L'état matrimonial lui-même n'a rien à voir avec la capacité d'éduquer un enfant et d'apprécier son intérêt[465]. »

De même, on reconnaît de plus en plus la nécessité d'accorder une protection juridique aux droits des minorités sexuelles[466]. Le Comité parlementaire sur les droits à l'égalité a conclu que « l'esprit général de l'article 15 de la *Charte* permet de comprendre "l'orientation sexuelle" au nombre des motifs de discrimination interdits par la Constitution[467] ». Bien que l'orientation sexuelle ne figure pas parmi les motifs de discrimination énumérés à l'article 15, il s'agit d'un motif analogue parce que les homosexuels et les lesbiennes constituent des minorités distinctes et isolées, victimes d'une tradition d'inégalité[468]. L'orientation sexuelle est maintenant un motif de discrimination illégale au Québec, en Ontario, au Manitoba et au Yukon[469].

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463. CANADA, CHAMBRE DES COMMUNES, SOUS-COMITÉ SUR LES DROITS À L'ÉGALITÉ, *Égalité pour tous : Rapport du Comité parlementaire sur les droits à l'égalité*, Ottawa, Imprimeur de la Reine, 1985, p. 40 (président : J. Patrick Boyer).

464. (1986) 34 D.L.R. (4e) 488 (C.S. C.-B.).

465. *Id.*, 497. Voir aussi *M. (N.)* c. *British Columbia (Superintendent of Family and Child Services)* (1986), 10 B.C.L.R. (2e) 234 (C.S.).

466. Voir James E. JEFFERSON, « Gay Rights and the *Charter* » (1985), 43 *U.T. Fac. L. Rev.* 70 ; Margaret LEOPOLD et Wendy KING, « Compulsory Heterosexuality, Lesbians, and the Law: The Case for Constitutional Protection » (1985), 1 *R.j.f.d.* 163 ; Arnold BRUNER, « Sexual Orientation and Equality Rights », dans A.F. BAYEFSKY et M. EBERTS (dir.), *op. cit.*, note 458, p. 457 ; Philip GIRARD, « Sexual Orientation as a Human Rights Issue in Canada 1969-1985 » (1986), 10 *Dalhousie L.J.* 267. Mais voir l'arrêt *Andrews*, précité, note 445. Pour un résumé de l'état du droit aux États-Unis, voir Note, « Developments in the Law: Sexual Orientation and the Law » (1989), 102 *Harv. L. Rev.* 1508. Voir aussi Philip GIRARD, « The Protection of the Rights of Homosexuals under the International Law of Human Rights: European Perspectives » (1986), 3 *A.C.D.P.* 3.

467. *Égalité pour tous*, *op. cit.*, note 463, p. 33.

468. Voir M. LEOPOLD et W. KING, *loc. cit.*, note 466 ; J.E. JEFFERSON, *loc. cit.*, note 466 ; *Watkins* c. *United States Army*, 837 F. 2d 1428 (1988), conf. par 875 F. 2d 699 (1989).

469. Charte du Québec, précitée, note 258, art. 10 ; *Code des droits de la personne* de l'Ontario, précité, note 458, mod. par L.O. 1986, ch. 64, art. 18 ; *Code des droits de la personne* du Manitoba, précité, note 458, al. 9(2)*h*) ; *Human Rights Act* du Yukon, précité, note 458, art. 6.

En somme, on peut d'ores et déjà affirmer que toute mesure législative visant à limiter l'accès à la procréation médicalement assistée devra être conçue de manière à éviter la discrimination fondée sur la situation de famille, l'état matrimonial ou l'orientation sexuelle. En revanche, le texte législatif qui exigerait que les candidats soient jugés en fonction de leurs qualités et aptitudes à titre de parents éventuels n'enfreindrait pas l'article 15. Cette solution serait d'ailleurs en harmonie avec la législation sur l'adoption en vigueur au Canada et avec les recommandations contenues dans plusieurs rapports provinciaux concernant la procréatique. Par exemple, la législation ontarienne sur l'adoption a été modifiée récemment de sorte que les requérants célibataires puissent être considérés au même titre que les autres[470], comme c'est le cas dans toutes les autres provinces canadiennes[471]. De même, dans trois rapports provinciaux récents sur la procréatique, on a reconnu que ce serait enfreindre les lois sur les droits de la personne que de restreindre aux couples mariés l'accès à la procréation médicalement assistée. Ainsi, selon la Commission de réforme du droit de l'Ontario, une telle limitation :

> [TRADUCTION]
> [S]emble contrevenir à la législation sur les droits de la personne applicable dans la province. Au surplus, toute exclusion a priori, fondée simplement sur l'appartenance à un groupe particulier (par exemple, les personnes mariées) éliminerait automatiquement les célibataires ou les couples non mariés qui, à tout point de vue, feraient des parents convenables[472].

C'est pourquoi l'organisme ontarien a recommandé que l'admissibilité à un programme de procréation médicalement assistée [TRADUCTION] « soit limitée aux femmes célibataires stables, et aux hommes et aux femmes stables formant des couples stables, mariés ou non[473] ». De même, la Commission royale de la Colombie-Britannique a proposé que le critère soit [TRADUCTION] « l'aptitude à élever des enfants » :

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470. *Loi de 1984 sur les services à l'enfance et à la famille*, précitée, note 312, art. 140. Auparavant, la loi n'admettait la candidature des requérants célibataires que dans des « circonstances particulières ». Dans le document de base, les modifications apportées à la législation ont été expliquées comme suit :

> En plus de l'évolution des notions de mariage et de famille, les exigences imposées par le *Code des droits de la personne* de l'Ontario ont contribué à faire disparaître la réserve des « circonstances particulières » dans le cas des personnes célibataires qui font une demande d'adoption. La candidature de ces personnes pourra par conséquent être étudiée. Cependant, dans la plupart des cas, il est probable que l'on continuera à accorder une nette préférence a familles constituées de deux parents, en pensant aux meilleurs intérêts de l'enfant.

ONTARIO, MINISTÈRE DES SERVICES SOCIAUX ET COMMUNAUTAIRES, *La loi sur les services pour l'enfant et la famille : Projet de loi et document de base*, Toronto, le Ministère, 1983, p. 131.

471. *Child Welfare Act* (Alb.), précité, note 312, art. 56, mod. par S.A. 1988, ch. 15, art. 35 ; *Adoption Act* (C.-B.), précité, note 312, art. 3 ; *Loi sur les services à l'enfant et à la famille* (Man.), précitée, note 312, par. 66(1) et 71(1) ; *Loi sur les services à la famille*, (N.-B.), précitée, note 286, art. 66 ; *The Adoption of Children Act, 1972* (T.-N.), précité, note 312, par. 4(1) ; *Children and Family Services Act* (N.-É.), précité, note 312, par. 72(1) et (2) ; *Adoption Act* (Î.-P.-É.), précité, note 312, par. 3(1) ; C.c.Q., art. 598-599 ; *The Adoption Act* (Sask.), précité, note 312, al. 17(2)*b*) ; *Children's Act* (Yuk.), précité, note 201, par. 79(1).

472. CRDO, *op. cit.*, note 2, p. 158.

473. *Id.*, p. 275.

[TRADUCTION]
[L]e jugement porté sur la candidate en ce qui concerne le respect des mœurs en matière de mariage et de style de vie doit tenir compte de leur fluctuation continuelle et, chose plus importante encore, devrait être axé sur la conduite de la personne dont on peut démontrer qu'elle est liée directement à son aptitude à élever des enfants. Comme nous l'avons laissé entendre ci-dessus, pour l'évaluation de la candidate éventuelle à l'IAD [insémination artificielle avec sperme de donneur], on devrait mettre l'accent directement (et principalement) sur son aptitude à devenir une bonne mère. L'intérêt de l'enfant à naître doit l'emporter dans ce cas[474].

À supposer qu'il soit jugé nécessaire de restreindre l'accès à la procréation médicalement assistée, le critère retenu devrait, afin que soient respectées les exigences de l'article 15 de la Charte, s'apparenter à cette proposition, comme c'est actuellement le cas en matière d'adoption au Canada. En outre, à la lumière de la définition donnée au concept de discrimination par la Cour suprême[475], il faudra prendre des mesures pour s'assurer que les critères choisis pour réglementer l'accès à la procréatique n'imposent pas un fardeau injuste à une catégorie de candidats, définie par l'appartenance de ceux-ci à un groupe visé à l'article 15 (ou à un groupe analogue).

Considérons par exemple l'infertilité à titre de critère éventuel pour limiter l'accès à la procréatique. S'agissant de fécondation in vitro, le texte de loi qui poserait comme condition d'admissibilité la preuve de l'infertilité serait inattaquable sur le plan constitutionnel. La fécondation in vitro est une intervention à laquelle se soumettront surtout les femmes infertiles ; celles qui sont fertiles peuvent en effet porter des enfants sans y avoir recours. Cela dit, faire de l'infertilité une condition préalable de l'accès à la maternité de substitution ou à l'insémination artificielle soulèverait des objections fondées sur l'article 15 de la Charte. Une telle exigence imposerait en effet un fardeau disproportionné aux hommes et aux femmes fertiles qui souhaitent exercer leur droit à la procréation sans rapports sexuels. Ce groupe d'hommes et de femmes est caractérisé par leur absence de partenaire hétérosexuel, c'est-à-dire par leur état matrimonial ou leur orientation sexuelle. Le texte de loi qui imposerait l'infertilité à titre de condition à remplir pour bénéficier de l'insémination artificielle ou de la maternité de substitution ferait effectivement obstacle à l'exercice par ces hommes et ces femmes de leur droit de procréer. Et ce fardeau disproportionné imposé à des individus en raison de leur état matrimonial ou de leur orientation sexuelle constituerait de la discrimination au sens de l'article 15.

De plus, il faudra s'assurer que des critères apparemment neutres en ce qui concerne leur incidence sur les groupes visés à l'article 15 ou des groupes analogues, comme

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474. BRITISH COLUMBIA ROYAL COMMISSION ON FAMILY AND CHILDREN'S LAW, *Ninth Report of the Royal Commission on Family and Children's Law: Artificial Insemination*, Vancouver, la Commission royale, 1975, pp. 10-11. Voir aussi LAW REFORM COMMISSION OF SASKATCHEWAN, *Tentative Proposals for a Human Artificial Insemination Act*, Saskatoon, la Commission, 1981, pp. 1-3 :

> [TRADUCTION]
> [I]l semble qu'il y aurait violation du *Saskatchewan Human Rights Code* si un médecin ou un établissement de soins de santé offrant de manière générale des services d'insémination artificielle au public refusait d'inséminer une femme célibataire uniquement à cause de son état civil.

475. Voir *Andrews*, précité, note 445 ; *Turpin*, précité, note 421.

« l'aptitude à élever des enfants », ne sont pas appliqués en pratique de manière à imposer un fardeau inégal aux requérants qui ne sont pas mariés ou sont célibataires, homosexuels ou lesbiennes.

D. L'article premier

La loi qui porte atteinte à un droit ou à une liberté garanti par la Charte ne sera pas déclarée inconstitutionnelle si elle est conforme aux critères énoncés à l'article premier de la Charte, dont voici la teneur :

> La *Charte canadienne des droits et libertés* garantit les droits et libertés qui y sont énoncés. Ils ne peuvent être restreints que par une règle de droit, dans des limites qui soient raisonnables et dont la justification puisse se démontrer dans le cadre d'une société libre et démocratique.

Pour que la restriction d'un droit soit valide, elle doit être prescrite par une règle de droit. Cette exigence a été expliquée en ces termes par le juge Le Dain :

> L'exigence que la restriction soit prescrite par une règle de droit vise surtout à faire la distinction entre une restriction imposée par la loi et une restriction arbitraire. Une restriction est prescrite par une règle de droit au sens de l'art. 1 si elle est prévue expressément par une loi ou un règlement, ou si elle découle nécessairement des termes d'une loi ou d'un règlement, ou de ses conditions d'application. La restriction peut aussi résulter de l'application d'une règle de *common law*[476].

C'est dire que toute limitation de l'accès à la procréation médicalement assistée qui constituerait une dérogation aux dispositions de la Charte doit être énoncée dans la législation. Les restrictions découlant de l'application de lignes directrices ou d'autres directives n'ayant pas force de loi ne seraient pas considérées comme « prescrites par une règle de droit » au sens de l'article premier.

En ce qui concerne les autres exigences de l'article premier, le cadre fondamental a été établi par la Cour suprême dans l'arrêt *R.* c. *Oakes*[477]. En l'espèce, la Cour a décidé que l'objet de la loi devait être suffisamment important pour justifier l'atteinte portée et que les moyens choisis devaient être raisonnables et proportionnés aux objectifs poursuivis.

Pour ce qui est de l'objet de la loi, les types d'arguments pouvant être présentés devant les tribunaux en application de l'article premier sont soumis à certaines restrictions. En premier lieu, l'objet de la loi ne peut être invoqué s'il dépasse les compétences du Parlement ou de la législature, ou s'il porte par ailleurs lui-même atteinte aux dispositions de la Charte[478]. En second lieu, l'objectif allégué pour justifier la limitation des droits garantis doit réellement sous-tendre la législation en cause et ne pas être un objectif inventé après le fait pour appuyer l'argument présenté devant les tribunaux[479].

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476. *R.* c. *Therens*, [1985] 1 R.C.S. 613, 645.

477. [1986] 1 R.C.S. 103.

478. *R.* c. *Big M Drug Mart Ltd.*, [1985] 1 R.C.S. 295, 362 (voir les motifs du juge Dickson, alors juge puîné).

479. *Id.*, 362.

Hormis ces restrictions, les tribunaux ont eu tendance à accepter les objectifs législatifs comme suffisamment importants pour justifier une atteinte aux droits garantis : la plupart des cas portent sur la question de savoir si les limites apportées à ces droits étaient raisonnables dans les circonstances. À cet égard, on peut difficilement prédire de quelle façon les tribunaux appliqueront l'article premier à une loi limitant l'accès à la procréation médicalement assistée. De nos jours, on n'étonnera personne en disant que la Cour suprême est partagée quant à l'interprétation de l'article premier de la Charte et force est de constater que la disposition n'est pas toujours appliquée de façon uniforme[480]. Dans certaines causes, les tribunaux ont insisté pour que le législateur fournisse des motifs très rigoureux, alors que dans d'autres, les tribunaux se sont montrés très indulgents[481]. En effet, la jurisprudence récente laisse sans réponse la question centrale concernant la norme d'examen à appliquer dans les causes portant sur les droits à l'égalité, c'est-à-dire la question de savoir si différentes normes doivent être appliquées selon la nature de l'affaire et, dans l'affirmative, de quelle nature sont ces normes[482]. Voilà qui complique singulièrement la tâche de prédire comment un tribunal pourrait appliquer l'article premier aux questions abordées dans la présente étude.

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480. Marc GOLD, « Of Rights and Roles: The Supreme Court and the Charter » (1989), 23 *U.B.C. L. Rev.* 507 ; Robin M. ELLIOT, « The Supreme Court of Canada and Section 1 — The Erosion of the Common Front » (1987), 12 *Queen's L.J.* 277 ; Lorraine Eisenstat WEINRIB, « The Supreme Court of Canada and Section One of the Charter » (1988), 10 *Supreme Court L.R.* 469.

481. Voir *R.* c. *Edwards Books and Art Ltd.*, [1986] 2 R.C.S. 713 ; *R.* c. *Jones*, précité, note 340.

482. La division de la Cour est claire dans l'arrêt *Andrews*, précité, note 443. Voir Marc GOLD, « Comment: *Andrews* v. *Law Society of British Columbia* » (1989), 34 *R.D. McGill* 1063.

CHAPITRE TROIS

Le rôle de l'État

Même si la procréation médicalement assistée ne fait actuellement l'objet d'aucun texte législatif spécifique au Canada[483], elle obéit à certains mécanismes de contrôle[484]. Nous devons donc apprécier la suffisance de ces mécanismes avant de décider de l'opportunité d'une intervention législative dans le domaine. De façon générale, nous devons également, avant de recommander une intervention plus directe de l'État en la matière, nous interroger sur le rôle même de l'État et des autorités fédérales à ce chapitre.

I. Les mécanismes de contrôle existants et leur portée

Parmi les mécanismes de contrôle existants nous retrouvons : le contrôle individuel fondé sur la conscience individuelle et le libre choix des parties ; le contrôle professionnel et socio-professionnel qui vise la qualité de l'acte médical et l'aspect éthique de l'application des découvertes scientifiques ; le contrôle collectif exercé par les comités permanents d'éthique (provinciaux et nationaux) et les tribunaux ; enfin, le contrôle législatif et réglementaire.

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483. À l'exception des dispositions concernant la filiation dans certaines provinces. Voir, à ce sujet, *supra*, ch. II.

484. Voir Guy ROCHER, « Pour une sociologie des ordres juridiques » (1988), 29 *C. de D.* 91 particulièrement aux pp. 117-118 :

> La profession médicale a derrière elle une très longue tradition d'auto-régulation de ses membres. Elle est à cet égard un très ancien ordre juridique non étatique. En l'absence de législation ou de jurisprudence, le Collège des médecins a lui-même établi des règles ou normes, un code de déontologie qui tiennent lieu de droit pour les membres de la Corporation. Dans les hôpitaux, les médecins, par des comités d'éthique, des comités de discipline ou autrement, produisent des normes régissant leur conduite et leurs rapports avec leurs patients (et avec d'autres personnels médicaux). La profession médicale est un cas typique où des agents ou appareils ont eu une autorité reconnue pour élaborer, interpréter et appliquer des règles ayant tous les caractères du juridique, sans relever de l'État. [...] Tout cela n'exclut évidemment pas qu'intervienne la régulation par l'État. Ce qu'il est important d'analyser alors, c'est la source précise de cette régulation étatique : quel ordre juridique non étatique jouit du crédit, du pouvoir, de l'influence nécessaires pour faire accepter ses normes ? Quel compromis la régulation étatique (celle du législateur ou celle d'un tribunal) réalisera-t-elle entre les normes de plusieurs ordres juridiques non étatiques concurrents ?

A. Le contrôle individuel : la conscience et la liberté de choix des individus[485]

La priorité absolue est ici donnée à la liberté individuelle et au respect de la vie privée. Les particuliers s'organisent comme ils l'entendent, et aucun jugement de valeur n'est porté sur leur choix. L'appréciation des risques et des avantages qu'impliquent la procréation médicalement assistée et la décision d'y recourir ou non relèvent du libre arbitre des intéressés. Le rôle du législateur peut être actif ou passif selon qu'il consacre spécifiquement dans un texte la liberté de choix, ou qu'il l'approuve implicitement par son silence[486]. Sans intervenir d'emblée, il peut néanmoins attacher certaines conséquences aux choix individuels. C'est ainsi que, tout en s'abstenant de s'immiscer dans les décisions de contracter mariage ou de fonder une famille, il établit, sur les plans patrimonial et extra-patrimonial, les droits et obligations des époux et des enfants, ainsi que la filiation de ces derniers.

Cette politique a l'avantage de mettre l'accent sur l'initiative et la responsabilité individuelles. Elle permet à chacun, dans une société pluraliste, de se comporter suivant les croyances qui lui sont propres, sans ingérence de l'État et sans que celui-ci prétende imposer à tous une morale donnée[487]. Elle évite tout conflit avec les droits à la liberté et à la vie privée, constitutionnellement garantis, que pourrait mettre en jeu la procréation. La décision de concevoir est donc une décision purement privée, un choix moral qui doit être laissé aux individus[488].

L'État n'intervient pas dans la procréation naturelle[489]. Comme l'a souligné la Commission de réforme du droit de l'Ontario, l'État a renoncé à invoquer l'intérêt véritable de l'enfant pour justifier une intrusion dans la vie des couples ou des individus. S'il l'a déjà fait au nom de motifs eugéniques et financiers, dans le cadre de législations prescrivant, par exemple, la stérilisation forcée des déficients mentaux, des criminels ou des minorités ethniques, ce genre de motivation n'a plus cours de nos jours[490] ; les chartes et la jurisprudence en sont garantes.

De plus, le traitement de la stérilité (traitements hormonaux, interventions chirurgicales, etc.) fait partie des services de santé offerts à la population, sans égard à la situation matrimoniale ni au profil psychologique des personnes qui y ont recours[491]. Dès lors, pourquoi vouloir traiter la procréation dite « artificielle » différemment de la procréation

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485. Au sujet de « private ordering approach », voir Frances E. Olsen, « The Family and the Market: A Study of Ideology and Legal Reform » (1983), 96 *Harv. L. Rev.* 1497, 1504.

486. CRDO, *op. cit.*, note 2, p. 106 et suiv.

487. John A. ROBERTSON, « Embryo Research » (1986), 24 *U.W.O. L. Rev.* 15, 27.

488. CRDO, *op. cit.*, note 2, p. 106 et suiv. ; J.A. ROBERTSON (1986), *loc. cit.*, note 385, 1040 ; THE AMERICAN FERTILITY SOCIETY, THE ETHICS COMMITTEE, *loc. cit.*, note 191, 5S.

489. Par exception, il peut intervenir pour sanctionner des relations sexuelles illicites. Dans ce cas, cependant, le motif est la protection de certaines personnes exposées à l'exploitation et non pas une intervention dans une décision commune de procréer : CRDO, *op. cit.*, note 2, p. 106 et suiv.

490. CRD, *La stérilisation et les personnes souffrant de handicaps mentaux*, Document de travail n° 24, Ottawa, Approvisionnements et Services Canada, 1979 ; Colloque de l'ASSOCIATION QUÉBÉCOISE POUR L'ÉTUDE COMPARATIVE DU DROIT, « L'affaire *Eve* et la stérilisation des déficients mentaux » (1987), 18 *R.G.D.* 641.

491. CRDO, *op. cit.*, note 2, p. 110.

naturelle ? La première ne pourrait-elle pas, à l'instar de la seconde, tomber sous le régime de la même politique de « laissez-faire », du moins en ce qui concerne la décision même de concevoir[492] ?

Pour les partisans de la non-intervention de l'État dans ce domaine, la société est en train d'intégrer toutes ces découvertes et finira par trouver normale leur application, comme cela a été le cas de bien d'autres par le passé. La plupart des défenseurs de la liberté de choix reconnaissent toutefois la nécessité d'attacher certaines conséquences juridiques aux choix individuels et d'assujettir à des contrôles l'application des techniques — ou à tout le moins de certaines d'entre elles. Ces contrôles seront étudiés plus loin, mais qu'il nous suffise de dire pour l'instant qu'ils ont généralement pour objectif la qualité des services offerts, c'est-à-dire, dans cette perspective, la protection des « sujets ». Quoi qu'il en soit, il n'est pas question pour les tenants de cette position de remettre en cause le bien-fondé même du recours à la procréatique.

La liberté individuelle peut aussi être préconisée, à ce stade, simplement parce que toute intervention est jugée prématurée, la réflexion sur ces questions n'ayant pas encore été assez poussée pour que l'on puisse se permettre d'édicter des normes. Il s'agit donc de poursuivre la démarche collective de réflexion[493]. Quoi qu'il en soit, la politique de la non-intervention de l'État rallie peu de suffrages. Elle laisse sans réponse toutes les questions fondamentales que pose à l'humain l'application des découvertes scientifiques en matière de procréation, et laisse les chercheurs consciencieux sans les balises dont ils ont besoin. L'administration de la justice en souffre également : par exemple, le statut juridique des enfants nés de la procréatique demeure incertain et l'autorité sur les gamètes et les embryons sombre dans le vide juridique.

L'incidence du contrôle individuel en matière de procréation médicalement assistée pourrait être accrue par l'éducation et la sensibilisation adéquates du public. Il s'agit de présenter à la population, de la façon la plus objective possible, les enjeux de la procréatique. Sur le plan individuel, tout d'abord : les avantages des diverses techniques, leurs inconvénients pour ceux qui y ont recours, les taux de succès et d'échec de chacune d'elles dans le contexte où elles sont appliquées, les risques physiques et psychologiques qu'elles comportent pour toutes les personnes concernées. Ensuite, pour les générations à venir et la société entière : les enjeux à plus ou moins long terme pour l'embryon, le fœtus et l'enfant à naître, le devenir de l'espèce humaine, le sort réservé aux embryons surnuméraires, les avantages que peuvent en retirer les chercheurs, en somme toutes les grandes questions qui sont débattues actuellement suivant diverses perspectives. Toutefois, il est difficile de garantir que l'éducation du public se fera de manière objective puisqu'elle sera inévitablement la synthèse de renseignements provenant de sources multiples. Elle pourrait donc être influencée par la fragmentation de l'information. Elle peut même être faussée par le triomphalisme de certains scientifiques et par la recherche du sensationnalisme qui caractérise parfois les médias.

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492. *Id.*, p. 118. Thomas A. EATON, « Comparative Responses to Surrogate Motherhood » (1986), 65 *Neb. L. Rev.* 686, 707.

493. J. RUBELLIN-DEVICHI, *loc. cit.*, note 317, 457-459.

Cette mesure peut aussi s'accompagner d'une promotion des valeurs en cause, de façon à raffermir le sens des responsabilités de tous les intéressés, et à rappeler que le respect de la dignité humaine doit prévaloir sur les intérêts particuliers et immédiats. Les positions prises par les autorités morales et religieuses vont dans ce sens[494].

Dans la même lignée s'inscrivent les positions des diverses autorités du domaine éthique dont nous reparlerons plus loin. Mais encore faut-il que ces positions soient expliquées dans le grand public, comme s'efforce de le faire le Comité consultatif national d'éthique pour les sciences de la vie et de la santé en France[495]. Dans ses recommandations, l'American Fertility Society insiste également sur la diffusion de l'information et sur le conseil moral et la persuasion pour favoriser les choix éclairés et modifier graduellement les attitudes[496].

Des démarches de cette nature sont indispensables à une meilleure connaissance dans l'ensemble de la population des véritables enjeux de la procréation médicalement assistée. Mais l'information de base doit être, au départ, non confessionnelle et apolitique. Elle ne doit pas non plus être identifiée à des groupes particuliers, même si ceux-ci ont évidemment un rôle très important à jouer, qu'ils soient formés de scientifiques, de professionnels de la santé ou de femmes. Si actifs que soient certains de ces groupes en matière d'éducation populaire, ils n'ont pas toujours l'objectivité nécessaire à la transmission d'une information neutre[497].

Quelle peut être l'auditoire des organismes éthiques et des autorités morales et religieuses ? Pour Jacqueline Rubellin-Devichi, les avis qu'émettent ces organismes et autorités ont une influence considérable sur l'opinion des citoyens[498]. Cette affirmation est sans doute vraie en Europe ; l'est-elle autant au Canada ?

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494. Voir notamment : Congrégation pour la Doctrine de la Foi, *Instruction sur le respect de la vie humaine naissante et la dignité de la procréation*, Cité du Vatican, Typographie Polyglotte Vaticane, 1987 ; Gérard Mémeteau, « Le Comité National Consultatif d'Éthique et l'enfant conçu », dans *La vie prénatale, biologie, morale et droit : Actes du VI^e^ Colloque national des Juristes Catholiques, Paris, 15-17 novembre 1985*, Paris, TÉQUI, 1986, p. 67 ; Edouard Bone et Jean-François Malherbe, *Engendrés par la science : enjeux éthiques des manipulations de la procréation*, Paris, Cerf, 1985, p. 33, mentionnant la suggestion en ce sens de certains lauréats du prix Nobel, à propos des « permis de reproduction » et des « tests de qualité » de l'enfant nouveau-né.

495. Comité consultatif national d'éthique pour les sciences de la vie et de la santé, *Journées annuelles d'éthique*, Paris, La Documentation française, 1986, p. 31.

496. The American Fertility Society, The Ethics Committee, *loc. cit.*, note 191, 21S et suiv., 73S et suiv.

497. À titre d'exemple, d'aucuns ne voient dans la procréatique qu'une exploitation du corps de la femme au profit de la recherche scientifique et de la production, au point de méconnaître l'apport à la procréation. Cette perception s'est manifestée au colloque international *Sortir la maternité du laboratoire*, Québec, Conseil du statut de la femme, 1988. Par contre, les études publiées, entre autres, par le Conseil du statut de la femme, *Nouvelles technologies de la reproduction : pratiques cliniques et expérimentales au Québec*, Québec, le Conseil, 1986 et par l'Alberta Advisory Council on Women's Issues, *Discussion Paper on New Reproductive Technologies: Medical, Legal and Ethical Implications*, Edmonton, the Council, 1988, témoignent de l'importante contribution de ces groupes.

498. *Loc. cit.*, note 317, 457.

La position de l'Église catholique, opposée à toute forme de procréation médicalement assistée, suscite des réserves[499]. Selon l'Église unie du Canada, dont la position est moins catégorique, l'insémination artificielle hétérologue peut constituer un choix légitime sur les plans éthique et moral[500]. La maternité de substitution elle-même pourrait être admissible dans des circonstances très exceptionnelles[501].

Mais une démarche d'éducation est-elle suffisante au regard des enjeux de la procréation médicalement assistée ? Il semble falloir répondre par la négative. L'éducation peut en effet sensibiliser mais ne saurait avoir de force contraignante. Elle ne peut donc protéger contre les dangers d'une utilisation abusive des techniques, ni contre leur mercantilisation. Comme le soulignent Jean-Louis Baudouin et Catherine Labrusse-Riou, se fier à l'autodiscipline est un leurre[502]. L'éducation du public est une étape essentielle, certes, puisque nous cherchons la ou les solutions à un problème non pas seulement individuel mais avant tout social. Elle peut décourager les recours abusifs ou inconsidérés à la technologie mais elle est tributaire de la volonté des intéressés d'y obtempérer.

B. Le contrôle professionnel

La qualité de l'acte médical peut être contrôlée, tant pour ce qui est de ses indications qu'en ce qui concerne son exécution. Ce contrôle peut dépasser le niveau pratique pour remettre en question, sur le plan moral, le bien-fondé des applications de la découverte scientifique ; c'est là le rôle de l'éthique. Les normes à ce chapitre peuvent émaner des corporations professionnelles ou des comités multidisciplinaires formés à cette fin.

1. L'exercice de la médecine

Acte thérapeutique, le traitement d'aide à la procréation relève tout naturellement de l'exercice de la médecine. Cela est certainement le cas des techniques plus complexes qui exigent des ressources et un environnement particuliers. L'insémination artificielle, par contre, peut aisément être pratiquée par le profane. Elle n'est toutefois pas exempte de risques.

Les médecins sont tenus de se conformer aux normes de l'exercice de la médecine, définies par leurs corporations professionnelles à l'intérieur des limites fixées par la jurisprudence. Ces normes visent à protéger le public contre les individus non qualifiés[503] —

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499. Congrégation pour la Doctrine de la Foi, *op. cit.*, note 494, p. 5 et suiv. : l'Église fonde son opposition sur la scission entre la relation sexuelle et la procréation, qui, dit-elle, ne respecte pas la dignité de la personne. Elle craint en effet la technicisation de la procréation. L'Ethics Committee de l'American Fertility Society a publié un second document de réflexion en réponse à l'Instruction de Rome : « Ethical Considerations of the New Reproductive Technologies » (1988), 49:2 (suppl. 1) *Fertil. Steril.*

500. Église unie du Canada, Division de la mission au Canada, *A Brief to the Royal Commission on New Reproductive Technologies*, 1991, pp. 9-10 [non publié].

501. *Id.*, p.12.

502. *Op. cit.*, note 214, p. 208.

503. *Ibid.*

c'est-à-dire l'acte médical de mauvaise qualité ou accompli illégalement — et à guider l'exercice de la médecine. Elles pourront être prises en considération par le tribunal en cas de conflit[504]. À supposer que les corporations ou associations professionnelles prennent position sur le fond, ainsi que certaines l'ont déjà fait[505], et posent des balises éthiques pour l'application des nouvelles techniques par leurs membres, il faudrait alors trouver les moyens de sanctionner efficacement la transgression de ces limites[506]. En effet, le grand défaut des normes est qu'elles n'ont pas force de loi à moins d'avoir été reprises dans un texte réglementaire comme c'est le cas, par exemple, des codes de déontologie professionnelle au Québec.

En France, le Conseil d'État préconise des sanctions précises en matière de déontologie professionnelle et engage les corporations professionnelles à prévenir les abus dans l'application des techniques nouvelles. Il laisse même entendre que des sanctions pénales pourraient être infligées en cas de non-respect des règles de fond et de procédure, et même des avis des comités d'éthique[507]. Cela dit, reste la difficulté de veiller à leur exécution, surtout lorsqu'il s'agit de choix aussi fondamentaux. D'autre part, une certaine tradition de secret et d'autonomie morale entoure les corporations professionnelles et laisse planer certains doutes sur leur aptitude à assurer un contrôle réel et suffisamment digne de confiance aux yeux de la population. De plus, si le contrôle de l'application des découvertes est laissé à ces organismes, les normes pourraient varier d'une corporation à l'autre, d'une province à l'autre, d'un pays à l'autre, et il serait impossible de dégager les règles uniformes que réclament la plupart des intéressés.

Enfin, comme le font remarquer les membres du Comité ministériel au Québec, « l'encadrement des pratiques en reproduction humaine relève d'une politique sociale qui

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504. Par exemple, des normes exprimées par l'American Fertility Society ont influencé le tribunal dans l'affaire *York* v. *Jones Institute*, précitée, note 208 (transfert d'un embryon congelé d'une clinique à une autre). Voir également P. WIDMER, « Les perspectives législatives, en particulier vues du Conseil de l'Europe », dans *Procréation artificielle, génétique et droit : Colloque de Lausanne des 29 et 30 novembre 1985*, Zurich, Schulthess Polygraphischer Verlag, 1986, p. 211, à la page 213. Pour une discussion générale relative aux rôles des tribunaux, voir, la rubrique « Les tribunaux », *infra*, p. 120.

505. À l'égard de l'ensemble des méthodes, ou de certaines d'entre elles seulement ; voir, à titre d'exemple, THE AMERICAN FERTILITY SOCIETY, THE ETHICS COMMITTEE, *loc. cit.*, note 191, 625 et suiv. ; l'Association est favorable à une large liberté en matière de procréation, mais s'oppose cependant à la maternité de substitution pour des raisons de convenance, et émet des réserves sur le processus lui-même. L'ACADÉMIE SUISSE DES SCIENCES MÉDICALES, dans *Directives médico-éthiques pour la procréation médicalement assistée*, Peter Splitz, l'Académie, 1990, admet la légitimité de la fécondation in vitro pour raisons médicales, chez les personnes mariées ou non mariées mais vivant dans des conditions analogues à celles de la vie conjugale (directive 3.1, p. 2), et rejette la maternité de substitution (directive 12.6, p. 5). Le Conseil de l'Ordre des médecins, en France, accepte l'aide à la procréation au sein du couple, émet des réserves sur l'intervention de donneurs étrangers, rejette la maternité de substitution et le don d'embryon : COMITÉ CONSULTATIF NATIONAL D'ÉTHIQUE POUR LES SCIENCES DE LA VIE ET DE LA SANTÉ, *op. cit.*, note 495, p. 33. Au Canada, les comités d'éthique de la SOCIÉTÉ CANADIENNE DE FERTILITÉ ET D'ANDROLOGIE et de la SOCIÉTÉ DES OBSTÉTRICIENS ET GYNÉCOLOGUES DU CANADA ont publié un document qui rassemble leurs recommandations sur l'ensemble des techniques de procréation médicalement assistée : *Ethical Considerations of the New Reproductive Technologies*, Toronto (Ont.), Ribosome Communications, 1990.

506. B.M. KNOPPERS et E. SLOSS, *loc. cit.*, note 272, 669, n. 3 et les rapports y cités.

507. CONSEIL D'ÉTAT, *Sciences de la vie : de l'éthique au droit*, 2e éd., Paris, La Documentation française, 1988, pp. 122-123.

ne doit pas être assimilée à l'élaboration des normes de qualité professionnelle des services » ; cette fonction ne doit donc « pas être laissée à la profession médicale ou aux autres professions directement impliquées[508] ».

En l'absence de normes édictées par sa corporation ou de règles élaborées à un autre niveau, le médecin se trouve devant un dilemme : doit-il, en matière de procréation médicalement assistée, se contenter de répondre à la demande ou doit-il, au contraire, s'interroger sur les valeurs en cause, sur la notion de bien commun et exercer son jugement[509] ? Laisser aux seuls professionnels de la santé le soin d'édicter des règles fondamentales dans un domaine aussi complexe revient à leur confier des responsabilités très lourdes.

2. Les comités d'éthique locaux

Il existe, dans le secteur des soins de santé, deux grands types de comités qui ont tous deux un rôle à jouer dans le contexte qui nous occupe : les comités de déontologie de la recherche et les comités d'éthique clinique. Sans refaire ici un historique complet, rappelons brièvement que l'intervention des premiers est obligatoire au Canada depuis 1978, pour toute recherche subventionnée sous l'égide du Conseil de recherches médicales du Canada : le projet doit être approuvé par un comité local, en conformité avec les critères généraux énoncés par le Conseil, avant d'être soumis à celui-ci[510]. Si une composition multidisciplinaire est souhaitable, elle n'est cependant pas obligatoire et, dans un certain nombre d'organismes, le comité est formé seulement de scientifiques. La déontologie de la recherche, elle aussi, a pour objectif primordial la protection des sujets tant sur le plan de l'inviolabilité de la personne que sur celui du droit à la vie privée. Le Conseil de recherches médicales a édicté des règles spéciales en matière de recherches sur l'embryon[511]. Elles sont d'une importance extrême car, dans la plupart des centres, la fécondation in vitro entraîne la production d'embryons surnuméraires. Pour ceux qui ne feront pas l'objet d'un don à un autre couple infertile, se posent les questions de la durée de la conservation, de l'expérimentation, de la destruction et du développement *ex utero*.

Un contrôle déontologique s'exerce dans la mesure où la recherche sur le traitement de l'infertilité coûte cher et est largement tributaire des subventions des organismes officiels.

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508. Ministère de la Santé et des Services sociaux, *Rapport du Comité de travail sur les nouvelles technologies de reproduction humaine*, Québec, le Ministère, 1988, p. 152.

509. Guy Durand, « La bioéthique est une des principales préoccupations de la profession médicale » (1987), 116:6 *L'Union médicale du Canada* 343, 350 ; voir aussi Charles H. Baron, « Fetal Research: The Question in the States » (1985), 15:2 *Hast. Cent. Rep.* 12, 15.

510. Voir Jean-Louis Baudouin, Monique Ouellette et Patrick A. Molinari, *Pour un conseil consultatif canadien d'éthique biomédicale*, document d'étude, Ottawa, Commission de réforme du droit du Canada, 1990, p. 13 et suiv.

511. Conseil de recherches médicales du Canada, *Lignes directrices concernant la recherche sur des sujets humains*, Ottawa, Approvisionnements et Services Canada, 1987, pp. 34-35. La plupart des travaux, rapports, recommandations mentionnés dans le présent document envisagent également cet aspect ; voir aussi *L'expérimentation biomédicale sur l'être humain*, *op. cit.*, note 7.

Cependant, ce contrôle ne remplit pas toujours parfaitement son rôle : les approbations au niveau local n'ont pas nécessairement toute la rigueur requise, et l'on dénonce surtout le manque de suivi des projets, une fois obtenue l'approbation initiale. Mais il y a plus : lorsque la recherche est réalisée par l'entreprise privée, ce contrôle devient inopérant[512]. De même, ce type de contrôle ne peut plus s'exercer à partir du moment où la technique a dépassé le stade expérimental. Or, c'est le cas de la plupart des techniques de procréation médicalement assistée, qui peuvent maintenant être pratiquées par les cliniques de fertilité et dont l'application relève désormais des comités d'éthique *clinique*.

Les comités d'éthique clinique ont connu une extraordinaire prolifération partout dans le monde depuis dix ans et font l'objet d'une abondante littérature[513]. Multidisciplinaires, ils sont généralement à même d'aborder les problèmes dont ils sont saisis dans une perspective beaucoup plus large. Leur rôle est essentiellement consultatif. En 1986, l'Association des hôpitaux du Canada recommandait la création de comités d'éthique dans tous les centres hospitaliers de quelque importance[514].

De façon générale, le comité d'éthique clinique intervient lorsque le médecin traitant estime avoir une décision difficile à prendre, ou en cas de désaccord avec la famille ou au sein de l'équipe traitante. Mais à moins que des règles internes de l'établissement ne rendent la consultation obligatoire dans certains cas, le médecin compétent est libre de traiter l'infertilité de ses patients comme il l'entend, c'est-à-dire d'administrer des traitements de procréatique suivant son jugement professionnel, pour peu que la technique envisagée ait dépassé le stade expérimental. Il ne faut donc pas s'étonner de la diversité des critères de mise en application.

En France, les CÉCOS se sont efforcés d'élaborer une politique éthique commune. En effet, « il est apparu que les problèmes soulevés dépassaient un plan purement technique et entraînaient obligatoirement une réflexion sur la nature même de la procréation artificielle par don de gamètes, sur sa signification, sa justification, ses risques et les limites à lui assigner[515] ». Mais cette politique ne s'applique qu'au sperme congelé, et non au sperme frais que les médecins restent libres d'utiliser à leur guise[516]. Le recours à un gynécologue privé permet de la même façon d'éluder ces règles[517]. D'autres divergences subsistent aussi, notamment sur le plan de la rémunération. Au Québec, le Comité ministériel[518] souligne que chaque clinique a ses règles propres.

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512. Les normes du Conseil de recherches médicales du Canada peuvent tout de même être appliquées par les comités d'éthique hospitaliers appelés à considérer les projets de recherche subventionnés par l'entreprise privée.

513. J.-L. Baudouin, M. Ouellette et P.A. Molinari, *op. cit.*, note 510, p. 7.

514. G. Durand, *loc. cit.*, note 509, 353, et J.-L. Baudouin, M. Ouellette et P.A. Molinari, *op. cit.*, note 510, p. 7.

515. P. Jalbert et G. David, « Problèmes génétiques liés à la procréation artificielle par don de gamètes : solutions adoptées par les CÉCOS » (1987), 16 *J. Gynécol. Obstétr. Biol. Reprod.* 547, 548.

516. J. Rubellin-Devichi, *loc. cit.*, note 317, 460 ; Alain Sériaux, « Droit naturel et procréation artificielle : quelle jurisprudence ? » *D.* 1985, 53, 54, n° 4.

517. Jacqueline Rubellin-Devichi, « Le droit, les pères et la paternité » (1988), 24:3 *Rev. Droit sanit. et soc.* 425, 435.

518. Ministère de la Santé et des Services sociaux, *op. cit.*, note 508, p. 107 et suiv.

Les comités locaux présentent quand même des avantages indéniables : outre leur rôle d'éducation, déjà mentionné, ils forment une structure très souple de fonctionnement, et ils permettent, lorsqu'ils sont composés adéquatement, de prendre le pouls de la société[519]. Les règles éthiques qui se dégagent peuvent à moyen terme inspirer le législateur. Cependant, comme on l'a fait remarquer[520], ces règles ne seront jamais qu'un palliatif à la carence du législateur car elles n'ont d'effet que dans la mesure où les patients acceptent de s'y soumettre. En cas de contestation, elles ne peuvent fonder une décision judiciaire, sauf si elles ont été incorporées de quelque manière à un texte législatif ou réglementaire[521].

Les codes d'éthique n'établissent en général que des normes minimales et les médecins, dans leurs rapports avec leurs patients, doivent tenir compte de l'intérêt et de la volonté de ceux-ci. À elles seules, les règles d'éthique ne permettent pas de faire face à la problématique soulevée par la procréation médicalement assistée[522].

C. Le contrôle de la collectivité

1. Les comités permanents d'éthique provinciaux et nationaux

Nous avons fait allusion plus haut aux règles existant dans le domaine de la recherche. La nécessité de réglementer l'expérimentation s'est imposée dès la fin de la Deuxième Guerre mondiale, lorsque ont été découvertes les expériences horrifiantes qui avaient été menées au mépris de l'humain, la poursuite du savoir justifiant tous les moyens. Les règles établies par les comités d'éthique de recherche ont une certaine force contraignante car les comités disposent de moyens de persuasion sur le plan financier. Habituellement, avant d'adopter des règles, ils procèdent à de larges consultations auprès des intéressés et de la population. Leurs activités ne semblent pas soulever de contestation[523].

En ce qui concerne non plus la recherche, c'est-à-dire l'acquisition de connaissances nouvelles, mais la mise en application de ces connaissances, la question éthique prend une dimension sociale beaucoup plus importante. Plusieurs auteurs et organismes proposent en conséquence la création d'un conseil national d'éthique, là où il n'en existe pas

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519. Cela est encore plus vrai à propos des comités nationaux : LeRoy WALTERS, « Ethics and New Reproductive Technologies: An International Review of Committee Statements » (1987), 17:3 (suppl.) *Hast. Cent. Rep.* 3.

520. Dominique THOUVENIN, « Éthique et droit en matière biomédicale » *D.* 1985, 21, 24-25, n° 12-13.

521. *Id.*, 23, n° 7.

522. B.M. KNOPPERS et E. SLOSS, *loc cit.*, note 272, 671, n. 7 et les rapports y mentionnés.

523. Pour un aperçu des principaux comités, voir G. DURAND, *loc. cit.*, note 509, 352 ; J.A. ROBERTSON, *loc. cit.*, note 487, 19. Voir aussi *L'expérimentation biomédicale sur l'être humain*, *op. cit.*, note 7 et J.-L. BAUDOUIN, M. OUELLETTE et P.A. MOLINARI, *op. cit.*, note 510.

encore[524]. L'American Fertility Society souligne aussi la nécessité d'une consultation à l'échelle nationale. Selon Gorovitz, [TRADUCTION] « notre société a besoin d'un organisme chargé de réfléchir et de formuler des recommandations qui tiennent compte de toute la gamme de sentiments que peuvent inspirer ces questions. Cet organisme devra avoir suffisamment de liberté et de courage pour prendre le parti le plus justifié, tout en étant conscient qu'une prise de position, quelle qu'elle soit, fera toujours des détracteurs[525]. »

Mais, en l'absence de pouvoir de contrainte, comment imposer un choix éthique à ceux qui ne le partagent pas ? Comment, en l'occurrence, empêcher la commercialisation, dont les partisans ne connaissent que la loi de l'offre et de la demande ? Le temps perdu à la recherche d'un impossible consensus permet le développement débridé des nouvelles techniques. Et cette recherche traduit « les désarrois d'une société qui, en l'absence de projet clair, entend s'en remettre à un comité des sages [...] L'avenir serait-il aux lois éthiques plutôt que politiques[526] ? » Doit-on y voir l'abdication des pouvoirs publics ?

2. Les tribunaux

En l'absence de législation explicite, les tribunaux figurent parmi les premières institutions publiques auxquelles on s'adresse pour régler les conflits. C'est ainsi que les questions fondamentales sont portées à l'attention du public et que s'engagent les débats nécessaires à toute forme d'intervention, dont celle du législateur[527]. La publicité qu'assurent les médias permet aux tribunaux de jouer un rôle de sensibilisation. [TRADUCTION] « Les objectifs publics peuvent subir l'influence des débats judiciaires et des médias, et le choix des politiques législatives peut, à son tour, s'en trouver modifié[528] ».

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524. Notamment, CONSEIL DE L'EUROPE, A.P., 38e sess., IIe partie, *Textes adoptés*, *Recommandation 1046 (1986) relative à l'utilisation d'embryons et fœtus humains à des fins diagnostiques, thérapeutiques, scientifiques, industrielles et commerciales*, art. 14 vii (ci-après *Recommandation 1046 (1986)*) ; Rapport Warnock, *op. cit.*, note 425 ; THE COMMITTEE TO CONSIDER THE SOCIAL, ETHICAL AND LEGAL ISSUES ARISING FROM IN VITRO FERTILIZATION, *Report on the Disposition of Embryos Produced by In Vitro Fertilization*, Melbourne, F.D. Atkinson Government Printer, 1984 (président : Louis Waller) (ci-après Rapport Waller) ; *Fécondation in vitro, analyse du génome et thérapie génétique : Rapport du groupe de travail constitué en commun par le ministère fédéral de la Recherche et de la Technologie et le ministère fédéral de la Justice* de la République fédérale d'Allemagne, trad. par C. Bergeal, Paris, La Documentation française, 1987 (président : Ernst Benda) (ci-après Rapport Benda) ; B.M. KNOPPERS et E. SLOSS, *loc. cit.*, note 272, 670 ; Jacqueline A. PRIEST, « The Report of the Warnock Committee on Human Fertilisation and Embryology » (1985), 48 *Mod. L. Rev.* 73, 74 ; Samuel GOROVITZ, « Engineering Human Reproduction: A Challenge to Public Policy » (1985), 10 *J. Med. Phil.* 267, 271. Voir aussi J.-L. BAUDOUIN, M. OUELLETTE et P.A. MOLINARI, *op. cit.*, note 510.

525. S. GOROVITZ, *loc. cit.*, note 524.

526. D. THOUVENIN, *loc. cit.*, note 520, 26, nº 15.

527. À titre d'exemple, mentionnons l'affaire *Quinlan*, 70 N.J. 10 (1976) discutée dans J.-L. BAUDOUIN, M. OUELLETTE et P.A. MOLINARI, *op. cit.*, note 510, p. 7. Voir également les commentaires de la Cour suprême du New Jersey dans *Baby M*, précité, note 305, 1264.

528. Veronica L. PAYNE, « The Regulation of Surrogate Motherhood » (1987), 17 *Fam. L.* 178.

Les lois actuelles ne traitent pas directement de procréation médicalement assistée[529]. Cela dit, on y trouve à l'occasion des dispositions qui peuvent embrasser certaines situations nouvelles : « Ainsi le concept d'intérêt de l'enfant, concept élastique qui donne place à beaucoup d'interprétations, a jusqu'ici fondé des décisions en matière de nouvelles technologies de reproduction et notamment de maternité de substitution[530]. »

Toutefois, l'application des règles existantes à une situation non prévue au moment de leur élaboration, comme le recours aux principes de justice naturelle, n'est pas sans causer de difficultés.

Pour un certain nombre de points soulevés par la procréation médicalement assistée, les textes existants ne sont guère utiles aux tribunaux. Or, cet état de choses peut les amener à éluder les questions fondamentales qui sous-tendent les conflits dont ils sont saisis. C'est ainsi qu'en France, dans l'affaire *Parpalaix*, le jugement a porté uniquement sur la remise du sperme congelé à la veuve, alors que la véritable question socio-éthique était celle de l'insémination posthume[531]. De plus, si les pouvoirs discrétionnaires conférés aux juges peuvent parfois tourner à l'avantage des parties à un conflit, ils sont la source d'une grande disparité dans les décisions judiciaires, ce qui laisse le justiciable dans l'incertitude.

La voie judiciaire a ainsi ses limites et n'offre pas de solution globale aux problèmes que pose la procréation médicalement assistée.

D. Le contrôle législatif et réglementaire

1. Le contrôle législatif

Dans la mesure où les tribunaux, les comités d'éthique, les corporations professionnelles et la conscience individuelle des citoyens s'avèrent impuissants à définir les limites de l'application de la procréation médicalement assistée, ou du moins de certains aspects de celle-ci, l'intervention du législateur, avec toutes les réserves et nuances qui s'imposent, pourrait être nécessaire. Elle peut l'être également pour remédier à l'impuissance où se trouve le droit positif à l'égard de certains des effets de la procréatique, par exemple la filiation de l'enfant ou l'autorité sur les gamètes et l'embryon, en vue d'uniformiser la

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529. Voir *supra*, note 482.

530. Michèle Rivet, « Le rôle du juge et des parlements en matière de procréation assistée » (1990), 1:1 *Journal international de bioéthique* 49, 52.

> Dans tout le domaine de la filiation, le glissement qui s'est fait d'une vérité « sociale » à protéger, à une vérité « biologique » à reconnaître, a privilégié quelques aspects de vérité « fictive » ou « consensuelle ». Maintenant, c'est vers une vérité 'psychologique' qu'il tend, vérité qui émerge de la notion même d'intérêt de l'enfant, sujet de droit. Nos tribunaux auront sans doute encore à statuer sur des conflits de filiation revendiquée, conflit d'appartenance entre la femme porteuse qui voudra garder l'enfant et le père biologique qui le réclamera et ils pourraient alors utiliser ce concept d'intérêt de l'enfant.

Voir également *supra*, ch. II.

531. Précitée, note 206. Voir D.J. Jones, *loc. cit.*, note 148.

situation dans une province ou État, un pays, ou même au niveau international[532]. Cette voie peut aussi être privilégiée lorsqu'il s'agit d'examiner les valeurs de notre société à un moment donné de son histoire. Il n'est d'ailleurs pas un rapport ni un comité national qui ne recommande une intervention législative quelconque[533].

L'éducation du public peut sensibiliser celui-ci aux enjeux et éclairer la liberté de choix. Le contrôle professionnel et la réflexion éthique limiteront les risques d'excès dans l'application des techniques. Les tribunaux, par définition, n'interviennent qu'à l'occasion des litiges dont ils sont saisis, ce qui représente une infime proportion des cas de procréation médicalement assistée, même dans le contexte de la maternité de substitution[534].

Les mécanismes de régulation sociale et « l'émergence de normes hors du droit[535] » ont une incidence indéniable. Ils témoignent de l'intérêt et de l'engagement d'un nombre accru de citoyens. Mais l'intervention législative, outil extrême de contrôle et de sanction, comporte aussi, il ne faut pas l'oublier, ses écueils et difficultés.

Certains auteurs estiment que le droit positif étatique n'est pas la solution à toutes ces questions[536]. Une loi qui est adoptée et qui s'avère inapplicable en pratique risque d'être déconsidérée, manquant ainsi totalement son objectif[537]. D'aucuns craignent aussi que, malgré les apparences, la législation n'apporte pas nécessairement à tous une protection adéquate[538]. D'autres enfin soulignent le risque d'une intervention intempestive du législateur, sous la pression des tribunaux, de l'opinion publique et des médias[539], alors qu'un consensus ne s'est pas encore formé[540].

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532. D.G. DICKMAN, « Social Values in a Brave New World: Toward a Public Policy Regarding Embryo Status and In Vitro Fertilization » (1985), 29 *St. Louis U. L.J.* 817 ; J.A. ROBERTSON, (1986) *loc. cit.*, note 385, 952, n. 48 ; S. GOROVITZ, *loc. cit.*, note 524, 269, 271 ; A. SÉRIAUX, *loc. cit.*, note 516, 54, n° 4 ; B.M. KNOPPERS et E. SLOSS, *loc. cit.*, note 272, 667 et suiv. ; J.-L. BAUDOUIN et C. LABRUSSE-RIOU, *op. cit.*, note 214, p. 252.

533. Voir, entre autres, Rapport Warnock, *op. cit.*, note 425, Rapport Benda, *op. cit.*, note 524, Rapport Waller, *op. cit.*, note 525, CRDO, *op. cit.*, note 2, MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *op. cit.*, note 508, BARREAU DU QUÉBEC, *loc. cit.*, note 3, CONSEIL D'ÉTAT, *op. cit.*, note 507.

534. Voir notamment les études sur ce phénomène au Canada, Margrit EICHLER et Phebe POOLE, *La fréquence des contrats de grossesse conclus avant la conception et intéressant des Canadiens*, étude préparée pour la CRD, septembre 1988 [non publiée] ; MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *op. cit.*, note 508. CONSEIL DU STATUT DE LA FEMME, *op. cit.*, note 497 ; ALBERTA ADVISORY COUNCIL ON WOMEN'S ISSUES, *op. cit.*, note 497.

535. Michèle RIVET, « Les nouvelles technologies de reproduction : les limites de la loi », dans Gérald A. BEAUDOIN (dir.), *Vues canadiennes et européennes des droits et libertés : Actes des Journées Strasbourgeoises 1988*, Cowansville (Qc), Yvon Blais, 1989, p. 443 à la page 449 et suiv. Voir G. ROCHER, *loc. cit.*, note 484 ; Jean-Guy BELLEY, « *L'État et la régulation juridique des sociétés globales* » (1986), 18 *Sociologie et sociétés* 11.

536. J. RUBELLIN-DEVICHI, *loc. cit.*, note 317, 457-459 et n. 7 ; S. GOROVITZ, *loc. cit.*, note 524, 271.

537. J. RUBELLIN-DEVICHI, *loc. cit.*, note 317, 457-459 ; S. GOROVITZ, *loc. cit.*, note 524, 271 ; COUNCIL FOR SCIENCE AND SOCIETY, *Human Procreation: Ethical Aspects of the New Techniques*, Oxford, Oxford University Press, 1984, p. 84, n° 8.6 ; R.L. KIDDER, *op. cit.*, note 9.

538. Hutton BROWN et autres, « Legal Rights and Issues Surrounding Conception, Pregnancy, and Birth » (1986), 39 *Vand. L. Rev.* 597, 665.

539. V.L. PAYNE, *loc. cit.*, note 528, 178.

540. CRDO, *op. cit.*, note 2, p. 124 ; V.L. PAYNE, *loc. cit.*, note 528, 180 ; J. RUBELLIN-DEVICHI, *loc. cit.*, note 317, 496 ; MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *op. cit.*, note 508, p. 140 ; COUNCIL FOR SCIENCE AND SOCIETY, *op. cit.*, note 537, pp. 83-84, n° 8.5. Pour une étude générale de cette question, voir R.L. KIDDER, *op. cit.*, note 9.

Il importe assurément de se garder de toute décision précipitée. Il faudra prendre le temps de peser le pour et le contre de l'intervention, de sonder l'opinion publique, de définir les bases éthiques sur lesquelles il faut agir[541] et enfin prendre soin d'éviter le dogmatisme.

2. La réglementation de la procréatique

L'intervention législative peut être globale ou parcellaire, ou peut tout simplement viser à réglementer l'application des techniques. La multiplication des centres, publics ou privés, où est pratiquée la procréation médicalement assistée rend évidemment plus difficile l'exercice d'un contrôle, que ce soit sur le plan des principes, sur celui de la qualité des services professionnels ou encore sur celui du coût des soins de santé. C'est pourquoi nombre de rapports proposent l'établissement d'un système de permis pour les établissements et les professionnels dispensant une aide à la procréation[542]. En Angleterre, selon la Commission Warnock, l'organisme qui délivre les permis (*licensing authority*) devrait avoir le pouvoir d'édicter des normes pour la pratique professionnelle et la recherche en la matière, et de conseiller l'État sur des points précis[543]. C'est aussi le parti adopté en Australie par certains États[544]. À l'intérieur de ce cadre, les corporations professionnelles sont évidemment étroitement associées à la formulation des normes établies dans l'intérêt public. Pour le Comité ministériel du Québec, l'autorité responsable serait le ministère de la Santé et des Services sociaux, à qui il appartiendrait de mettre sur pied un groupe d'évaluation chargé de visiter périodiquement les établissements[545]. Le Conseil d'État français préconise pour sa part un mécanisme d'accréditation reposant sur les conditions énoncées par la loi et comportant des sanctions administratives (retrait du permis) ou pénales (pour les dirigeants) en cas d'infraction, où la responsabilité civile entre aussi en jeu[546].

Ce type de réglementation, inévitable si l'on vise à la prise en charge des traitements de l'infertilité par les services sociaux, assure aussi l'uniformité des normes pour tous les centres, c'est-à-dire une plus grande équité pour les citoyens, ainsi que la transparence de la pratique[547]. Il ne s'agit pas d'empêcher les comités d'éthique locaux de se prononcer sur des cas particuliers. Cette formule permettrait toutefois une meilleure gestion de toutes les données relatives à la procréation assistée. Le Conseil de l'Europe recommande que soit constitué un registre de tous les centres dûment accrédités et autorisés[548]. La

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541. V.L. PAYNE, *loc. cit.*, note 528.

542. Voir *infra*, annexe A, p. 183.

543. Rapport Warnock, *op. cit.*, note 425, p. 119 et suiv. Cependant, suivant le Rapport Benda, *op. cit.*, note 524, ces normes relèveraient de la législation.

544. Voir *infra*, annexe A, p. 209 et suiv. Comparer CRDO, *op. cit.*, note 2, pp. 129, 275 et suiv.

545. MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *op. cit.*, note 508, p. 152.

546. CONSEIL D'ÉTAT, *op. cit.*, note 507, pp. 63-64, art. 9-12. Le recours à la procréation médicalement assistée, conformément à la loi, doit être pris en charge par la Sécurité sociale : *id.*, p. 67, art. 53.

547. Voir MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *op. cit.*, note 508, p. 152. COMITÉ CONSULTATIF NATIONAL D'ÉTHIQUE POUR LES SCIENCES DE LA VIE ET DE LA SANTÉ, *op. cit.*, note 495, p. 30.

548. *Recommandation 1046 (1986)*, précitée, note 524, art. 14 vi.

Commission de réforme du droit de l'Ontario souligne d'autre part que l'éloignement des centres peut avoir un effet sur l'accessibilité, mais cet état de choses n'est pas propre au traitement de l'infertilité et vaut pour tous les soins de santé quelque peu spécialisés.

II. Le rôle de l'État et des autorités fédérales dans le processus de réforme

A. Le rôle de l'État

L'intervention de l'État dans le domaine de la procréation médicalement assistée devrait tendre à promouvoir les valeurs jugées fondamentales par la société[549], tels le respect de la vie privée de l'individu et de son autonomie génésique[550], le respect de l'intégrité physique et psychologique des patients[551], l'égalité[552], la protection de la vie[553], de même que la protection toute particulière des enfants et des autres personnes qui ne peuvent se protéger elles-mêmes ou qui, en raison de leur incapacité, sont vulnérables et peuvent être facilement exploitées[554]. En fait, la société canadienne tend à considérer qu'un grand nombre de ces valeurs constituent des droits fondamentaux incarnant sur le plan juridique le concept moral de la dignité humaine[555].

Ces valeurs et ces droits permettent de définir les divers rôles que l'État peut être appelé à jouer dans le domaine de la procréation médicalement assistée. D'une part, au regard des droits à la vie privée, à la confidentialité et à l'autonomie, l'État serait

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549. En France, Catherine LABRUSSE-RIOU, « Servitude, servitudes », dans Bernard EDELMAN et Marie-Angèle HERMITTE (dir.), *L'homme, la nature et le droit*, Paris, Christian Bourgois, 1988, p. 308, à la page 326 affirme : « Si nous voulons humaniser la vie, la fonction de l'ordre public est d'une part d'instituer l'Humain comme différent de la chose ou du vivant non humain, et d'autre part de protéger la personne dans son intégrité, sa dignité, sa nature de sujet. »

550. Voir *R.* c. *Jones*, précité, note 340, 318-319 et *La stérilisation et les personnes souffrant de handicaps mentaux*, *op. cit.*, note 490, p. 70 (droit à la procréation) ; *Les crimes contre le fœtus*, *op. cit.*, note 7, p. 41.

551. *R.* c. *Morgentaler*, précité, note 340, 60-63.

552. Voir la *Loi canadienne sur les droits de la personne*, précitée, note 458, art. 3 (interdisant notamment la discrimination fondée sur la situation de famille ou l'état matrimonial, sur le sexe, sur la déficience), et l'art. 15 de la *Charte canadienne des droits et libertés*, précitée, note 10. Quant aux obligations imposées au gouvernement fédéral par le droit international en matière de prévention de la discrimination et de promotion de l'égalité suivant les traités internationaux auxquels le Canada est partie, voir le *Pacte international relatif aux droits civils et politiques*, 16 décembre 1966, R.T. Can. 1976 nº 47, 999 R.T.N.U. 187, art. 26.

553. Voir *R.* c. *Wetmore*, [1983] 2 R.C.S. 284, 288-289, et *Labatt* c. *Procureur général du Canada*, [1980] 1 R.C.S. 914, 932-934 (les objectifs traditionnels du droit pénal consistent notamment à assurer la sécurité, la santé et les bonnes mœurs publiques), où la Cour examine les arrêts *Russell* c. *The Queen* (1882), 7 App. Cas. 829 (C.P.) et *Reference re Validity of Section 5(a) of the Dairy Industry Act*, [1949] R.C.S. 1. Voir également, *R.* c. *Crown Zellerbach Canada Ltd.*, [1988] 1 R.C.S. 401, 442, 447 (où l'on fait une distinction entre les compétences de l'État en droit pénal et celles en matière de paix, d'ordre et de bon gouvernement pour protéger la santé nationale).

554. Voir *E.* (*M^me^*) c. *Eve*, précité, note 389.

555. Voir *R.* c. *Morgentaler*, précité, note 340, 164-166.

malavisé de s'immiscer dans les choix individuels en matière de procréation. C'est ce qui a suscité la célèbre remarque faite par l'ancien premier ministre Trudeau — « l'État n'a pas sa place dans la chambre à coucher des citoyens » — lorsqu'a été dépénalisée l'incitation à utiliser des moyens contraceptifs, entre autres, il y a plus de vingt ans[556]. Cette position a également donné lieu à des attaques véhémentes contre la réglementation par l'État des techniques de procréation assistée et contre le pouvoir de l'État de décider qui peut procréer[557].

D'autre part, devant l'engagement de la société à défendre les droits et les intérêts des enfants[558] et de protéger les personnes qui sont incapables de le faire elles-mêmes, l'État semble devoir jouer un rôle actif dans la promotion de la santé génésique et la vie de famille. Ce point de vue vient légitimer les lois qui autoriseraient les enfants nés grâce à la procréation médicalement assistée à consulter des dossiers confidentiels pour y puiser des renseignements médicaux ou génétiques essentiels à leur santé.

Quoi qu'il en soit, il existe entre ces deux positions extrêmes où l'État fait figure soit d'oppresseur, soit de protecteur-libérateur, toute une gamme de rôles de soutien qu'il peut assumer afin de remplir son mandat démocratique en matière de procréation médicalement assistée : arbitre des conflits, fournisseur de services de santé, administrateur des Finances publiques, législateur, chercheur, protecteur de la santé et de la sécurité publiques et de la vie humaine, ardent et bienveillant défenseur des droits de la personne ou simple administrateur des registres des naissances[559]. Les rôles précis de l'État sont déterminés en partie par les rôles historiques, en constante évolution, qu'il a été appelé à jouer dans le domaine de la santé génésique, et en partie par les valeurs fondamentales, en constante évolution elles aussi, qui déterminent et structurent les rapports juridiques entre l'individu, la famille et l'État[560].

Un bon nombre de ces valeurs qui sont à l'origine des divers rôles assumés par l'État trouvent leur expression dans des mesures prises par les autorités à l'échelle locale, régionale et nationale. Ainsi, les Administrations provinciales et territoriales peuvent assujettir les praticiens et les cliniques spécialisés dans le traitement de l'infertilité et de la stérilité à l'obtention de permis et réglementer leur activité professionnelle, tout comme elles le font pour les sages-femmes, les obstétriciens et les hôpitaux. Elles pourraient aider leurs

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556. John Robert Colombo (dir.), *New Canadian Quotations*, Edmonton, Hurtig, 1987, p. 311 ; voir aussi S.C. 1968-69, ch. 41, art. 13, (modifiant l'ancien al. 159(2)c) — qui correspond aujourd'hui à l'al. 163(2)c) — du *Code criminel*). La loi modificative insérait également dans la *Loi sur les aliments et drogues* (précitée, note 301), des dispositions expresses relatives à la réglementation des moyens anticonceptionnels.

557. Comparer *La stérilisation et les personnes souffrant de handicaps mentaux*, *op. cit.*, note 490 ; affaire *Eve*, précitée, note 389 ; *Skinner* c. *Oklahoma*, précité, note 373 ; Aldous Huxley, *Le meilleur des mondes*, Paris, Plon, 1980.

558. Voir Martha Minow, « Rights for the Next Generation: A Feminist Approach to Children's Rights » (1986), 9 *Harv. Women's L.J.* 1, 18. Voir également B. Landau (dir.), *op. cit.*, note 282.

559. Voir D.J. Jones, *loc. cit.*, note 148, 540, n. 75.

560. Voir Michael D.A. Freeman, *The State, the Law and the Family*, Londres, Sweet & Maxwell, 1984, et « Symposium: The Family, the State and the Law » (1985), 18:4 *U. Mich. J.L. Ref.*

administrés à obtenir des services d'insémination artificielle et de fécondation in vitro et en payer les frais, comme elles le font pour le traitement chirurgical de l'infertilité. Elles pourraient exiger que les services de fertilité soient offerts sans discrimination, comme cela est le cas en matière d'adoption et de services hospitaliers[561].

B. Le rôle des autorités fédérales

Le rôle des autorités fédérales en matière de santé nationale et ses responsabilités publiques ont la même source. La protection de la vie, valeur qui trouve son expression dans la Constitution sous la forme de l'obligation du Parlement fédéral de protéger la santé et la sécurité des Canadiens en vertu de sa compétence en droit pénal[562], est aussi à l'origine de leur obligation de garantir l'innocuité et l'efficacité des agents thérapeutiques qui agissent sur la fertilité et la stérilité. Ainsi, l'Administration fédérale réglemente les tubes prothétiques utilisés dans la reconstruction des trompes de Fallope, les médicaments inducteurs de l'ovulation et les condoms — ces derniers aidant notamment à prévenir la propagation des maladies transmissibles sexuellement qui provoquent la stérilité[563]. Cette compétence du fédéral en matière de sécurité — que vient compléter sa compétence à l'égard du commerce interprovincial et international — s'étend à la réglementation de l'importation et de l'exportation des tissus reproducteurs, des médicaments et des instruments médicaux[564].

De même, en réprimant la publicité illégale et trompeuse au sujet des produits et services médicaux, le fédéral assume la promotion des valeurs suivantes : liberté, autonomie et équité[565]. Les poursuites intentées récemment par l'Administration américaine à propos

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561. Voir, par exemple, le *Code des droits de la personne* de l'Ontario, précité, note 458, art. 1, qui s'applique aux services et aux établissements, et *Peters* c. *University Hospital Board*, [1983] 5 W.W.R. 193 (C.A. Sask.).

562. Comparer *Wetmore*, précité, note 553, 288, 293 (la protection de la sécurité et de la santé publiques prévue par la *Loi sur les aliments et drogues* en tant que pouvoir conféré par le droit pénal) et la *Loi sur la quarantaine*, L.R.C. (1985), ch. Q-1, reposant sur les par. 91(11) et 91(27) de la *Loi constitutionnelle de 1867*, 30 & 31 Vict., R.-U., ch. 3. Pour un examen plus approfondi des pouvoirs conférés en vertu du droit pénal, voir François CHEVRETTE et Herbert MARX, *Droit constitutionnel*, Montréal, P.U.M., 1982, pp. 742-745, et Peter W. HOGG, *Constitutional Law of Canada*, 2e éd., Toronto, Carswell, 1985, pp. 399-402.

563. Voir la *Loi sur les aliments et drogues*, précitée, note 301. Le fédéral a approuvé l'utilisation du médicament inducteur de l'ovulation clomifène citrate, il y a environ 25 ans (voir *supra*, note 34).

564. Pour un examen des obligations imposées à l'Administration fédérale par la *Loi sur les aliments et drogues* (précitée, note 301) en matière d'importation, d'exportation et de quarantaine, voir CRD, *op. cit.*, note 254. À cet égard, Agriculture Canada applique depuis de nombreuses années déjà un programme national de protection de la santé afin de contrôler les milliers d'embryons d'animaux et les millions de doses de sperme qui franchissent les frontières annuellement. Voir le *Règlement sur les maladies et la protection des animaux*, C.R.C., ch. 296, art. 32, 50, 59, 84, 115, pris en vertu de la *Loi sur les maladies et la protection des animaux*, L.R.C. (1985), ch. A-11, remplacée récemment par la *Loi sur la santé des animaux*, L.C. 1990, ch. 21, art. 2, 14, 16, 19. Ces mesures semblent avoir été prises en vertu des compétences du fédéral en matière de droit pénal, de quarantaine, de commerce et d'agriculture.

565. Voir la *Loi sur les aliments et drogues*, précitée, note 301, art. 3, et *R.* c. *Gregory* (1973), 11 C.P.R. (2e) 32 (C.S.P. Qc) (revendications trompeuses et non corroborées en matière de santé aux termes de la *Loi relative aux enquêtes sur les coalitions*, S.R.C. 1970, ch. C-23). Pour un commentaire récent sur l'évolution des postes de compétence du droit pénal et du commerce national qui sont à l'origine de la législation fédérale sur la concurrence, voir Katherine E. SWINTON, *The Supreme Court and Canadian Federalism*, Toronto, Carswell, 1990, pp. 141-146, 294-300 ; Neil FINKELSTEIN, « Constitutional Law — Division of Powers — Constitution Act, 1867, Section 91(2) — Validity of Section 31.1, Combines Investigation Act: *General Motors of Canada Limited* v. *City National Leasing ; Quebec Ready Mix Inc.* v. *Rocois Construction Inc.* » (1989), 68 *R. du B. can.* 802.

d'une publicité illégale et mensongère entourant les taux de réussite de la fécondation in vitro illustrent ce rôle[566]. Dans le but de favoriser la prise de décisions éclairées, les lois de ce genre peuvent aider à protéger les consommateurs canadiens contre les menaces à leur santé et contre la publicité frauduleuse ou trompeuse lorsqu'ils achètent des produits et services pour remédier à leur infertilité ou à leur stérilité. En outre, le financement par Santé et Bien-être social Canada de la recherche sur l'infertilité, les traitements prodigués aux membres des Forces canadiennes[567], et le droit au congé payé de maternité et d'adoption conféré aux travailleurs par la loi[568] — mesures sociales tendant à épargner aux femmes l'obligation de choisir, à leur détriment, entre leur vie familiale et leur carrière — représentent des moyens additionnels grâce auxquels le fédéral peut promouvoir activement la santé génésique. En fait, dans l'État canadien moderne, les obligations du Parlement fédéral — consistant *a)* à protéger la santé et la sécurité publiques et les formes de vie, sur la base de sa compétence en droit pénal, *b)* à réglementer les échanges internationaux et interprovinciaux grâce aux pouvoirs qui lui sont conférés en matière de commerce et de quarantaine, *c)* à protéger et à promouvoir l'intérêt national en intervenant sur les questions urgentes d'intérêt national, *d)* à protéger les droits de la personne en s'acquittant des obligations que lui imposent à cet égard le droit canadien et la Charte en particulier, et *e)* à financer la recherche médicale et les services de santé sur la base de son pouvoir de dépenser — lui fournissent autant de fondements constitutionnels et juridiques sur lesquels il peut s'appuyer pour promouvoir la santé génésique[569].

Enfin, l'État peut également jouer un rôle critique — représentant peut-être même la quintessence de la démocratie — en encourageant dans la société les débats, les recherches, l'éducation et la réflexion sur la question de la procréation médicalement assistée, et en fournissant les tribunes publiques où peuvent s'exprimer toutes les nuances

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566. Voir : Proposed Consent Agreement with Analysis to Aid Public Comment, 55 Fed. Reg. 37961-62 (1990) ; *Federal Trade Commission* c. *Jacobson*, Cour distr. É.-U., Virginie, n° 89-0078-A, 18 mai, 1989 ; on a ordonné à une clinique de FIV de s'abstenir de faire de la fausse publicité quant aux chances de grossesse.

567. Les membres des Forces canadiennes peuvent obtenir, au Centre médical de la Défense nationale ou dans des hôpitaux affiliés, des traitements contre l'infertilité tels que l'insémination artificielle homologue, des médicaments inducteurs de l'ovulation et des recanalisations après une ligature des trompes ou une vasectomie. Communication personnelle au ministère de la Défense nationale, Bureau du directeur général des services de santé, 1990.

568. Voir la *Loi sur l'assurance-chômage*, L.R.C. (1985), ch. U-1, art. 18, 20, mod. par L.C. 1990, ch. 40, art. 12-14 (prestations accordées pendant 17 semaines pour un congé de maternité ou d'adoption), qui a été examinée dans l'arrêt *Brooks* c. *Canada Safeway Ltd.*, [1989] 1 R.C.S. 1219. Voir également le *Code canadien du travail*, L.R.C. (1985), ch. L-2, art. 206 (congé de maternité de 17 semaines en vertu de la loi), et *Schachter* c. *Canada*, précité, note 434 (demande de congé de paternité équivalent) ; la demande de pourvoi devant la Cour suprême du Canada a été accordée ; l'affaire a été prise en délibéré.

569. S'appuyant sur ces fondements constitutionnels, le gouvernement fédéral a déjà prévu dans la *Loi sur les aliments et drogues*, précitée, note 301, la *Loi sur la quarantaine*, précitée, note 562, la *Loi canadienne sur la santé*, L.R.C. (1985), ch. C-6, la *Loi sur le ministère de la Santé nationale et du Bien-être social*, L.R.C. (1985), ch. N-10, la *Loi relative aux enquêtes sur les coalitions*, L.R.C. (1988), ch. C-34, (nouvelle appellation : *Loi sur la concurrence*), et la *Loi sur le Conseil de recherches médicales*, L.R.C. (1985), ch. M-4, l'organisation d'un bon nombre de régimes relatifs à la sécurité nationale, à la protection de la santé, aux services de santé et au financement de ceux-ci. Voir *supra*, notes 562-565 et *infra*, note 578. Voir également Andrée Lajoie, Patrick A. Molinari et Jean-Marie Auby, *Traité de droit de la santé et des services sociaux*, Montréal, P.U.M., 1981, pp. 891-892.

de points de vue[570]. Créée récemment, la Commission royale sur les nouvelles techniques de reproduction a pour mission d'aider les autorités à remplir ce rôle grâce aux audiences publiques qu'elle a tenues dans une vingtaine d'endroits au Canada[571]. Ces débats publics peuvent influencer le choix des individus en matière de procréation, dans la mesure où ils permettent de mieux comprendre les répercussions actuelles de la procréation médicalement assistée et de guider ses applications futures.

En fait, ces démarches semblent constituer les fondements et le catalyseur nécessaires à la réalisation d'un consensus, à l'élaboration de normes et à l'amorce de réformes à l'échelle nationale. Les déclarations publiques et mesures législatives suscitées par diverses commissions royales d'enquête antérieures du Canada et, plus récemment, les déclarations d'organismes analogues en Australie, en France et au Danemark en sont la preuve[572]. Les questions impérieuses présentant un « intérêt national » et dont le fédéral assume la responsabilité[573] à divers titres continuent à se multiplier au Canada : la nécessité d'établir des règles minimales mais rigoureuses pour la sélection des donneurs de gamètes afin de protéger le public et la progéniture des receveuses éventuelles contre les maladies transmissibles ; l'inexistence à l'échelle nationale d'exigences minimales relatives au prélèvement, au traitement, au stockage et à la distribution interprovinciale ou internationale des gamètes[574] ; le statut juridique et moral des embryons congelés[575] ; les rapports

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570. Voir D.J. JONES, *loc. cit.*, note 148, 545.

571. Voir le décret C.P. 1989-2150.

572. Voir *infra*, annexe A, p. 183, et le décret C.P. 1976-781 créant le Conseil consultatif canadien de la situation de la femme en application de la recommandation figurant dans le *Rapport de la Commission royale d'enquête sur la situation de la femme au Canada*, Ottawa, Information Canada, 1970, pp. 439-442.

573. Certains aspects des questions liées à la procréation médicalement assistée ont pris une dimension nationale et pourraient exiger une ou plusieurs mesures législatives nationales et uniformes, comme l'a démontré l'incapacité dans laquelle se trouvaient certaines provinces de régler divers problèmes sans provoquer des « répercussions graves » pour les résidents d'autres provinces. Pour déterminer si un problème revêt un « intérêt national » justifiant l'intervention du Parlement fédéral par l'exercice de sa compétence en matière de « paix, d'ordre et de bon gouvernement », les tribunaux et le législateur doivent se demander si le problème ou la question en cause a une unicité, une particularité et une indivisibilité qui rendent nécessaire une loi nationale unique. L'un des critères applicables dans un tel cas consiste à déterminer s'il est réaliste de croire que la coopération des provinces pourrait régler le problème, compte tenu des conséquences que peut entraîner l'inaction de l'une d'entre elles. S'il ressort de l'analyse qu'une loi nationale est nécessaire, l'intervention du fédéral doit néanmoins être compatible avec les pouvoirs et responsabilités des provinces. Voir l'arrêt *Crown Zellerbach Canada Ltd.*, précité, note 553, 431-436 ; K.E. SWINTON, *op. cit.*, note 565, pp. 203-208 ; P.W. HOGG, *op. cit.*, note 562, p. 375, et Patrice GARANT, *La théorie des dimensions nationales : la recherche et l'expérimentation bio-médicales*, étude préparée pour la CRD, janvier 1990 [non publiée]. On a invoqué cette théorie pour justifier la création par le fédéral de la région de la Capitale nationale à Ottawa et pour la réglementation de la radiocommunication, de l'aéronautique, de la pollution de la mer et des stupéfiants. Voir *Crown Zellerbach Canada Ltd.*, précité, note 553, 424-429, 452.

574. On réclame de telles normes au Canada depuis quinze ans. Voir BRITISH COLUMBIA ROYAL COMMISSION ON FAMILY AND CHILDREN'S LAW, *op. cit.*, note 474, et *Rapport sur le sperme humain de 1981*, *op. cit.*, note 149.

575. Si l'on tient pour acquis que les embryons surnuméraires congelés ne devraient jamais être traités comme de « simples objets », quels sont les droits, les intérêts ou les obligations particulières qui définissent leur statut juridique dans différents contextes, notamment le décès ou le divorce des donneurs, ou d'autres situations semblables ? Voir *L'expérimentation biomédicale sur l'être humain*, *op. cit.*, note 7, p. 54 ; *Loi de 1985 sur le divorce*, précitée, note 332, art. 2, 16 ; *In re Estates of Elsa and Mario Rios*, précité, note 208 (les embryons congelés ne sont pas successibles). Voir en général la rubrique « L'autorité sur les gamètes et les embryons », *supra*, p. 46.

juridiques liant les donneurs anonymes de gamètes aux enfants nés de ces gamètes ; l'exploitation éventuelle des enfants et des femmes dans le cadre des contrats de maternité de substitution ; les divergences déroutantes mais évitables qui existent dans le calcul des taux de réussite de la fécondation in vitro[576]. Que ce soit parce qu'elles risquent de mettre en danger la vie, la santé et la sécurité des personnes, de porter atteinte aux valeurs et aux droits fondamentaux ou encore de remettre en question les différentes conceptions de la famille moderne, ces questions se conjuguent pour rendre inévitables certaines réformes juridiques et politiques dans la société canadienne.

Si des réformes s'imposent afin de remédier aux lacunes du droit, il faudrait sans doute commencer par s'attaquer aux ambiguïtés actuelles, en définissant mieux les droits, les intérêts et les obligations des personnes touchées par la procréation médicalement assistée, ainsi que la protection dont elles devraient bénéficier. Selon les points de vue, on pourra proposer, à juste titre, divers modèles d'attribution des droits et obligations. Quoi qu'il en soit, la recherche d'une juste répartition des droits et obligations doit constituer l'objectif collectif d'une société démocratique. Les réformateurs devraient aussi faire preuve d'imagination et être pleinement conscients du rôle que le droit peut jouer en réponse au besoin à la fois de dépendance et de liberté des êtres humains dans les multiples rapports qui existent entre l'enfant, l'adulte, la famille, la collectivité et l'État : [TRADUCTION] « L'objectif que nous devons viser consiste à concevoir des réformes qui aident les gens à s'aider eux-mêmes — des réformes qui tiennent compte tant des influences d'ordre public que des influences d'ordre privé qui agissent sur les relations humaines, ainsi que des circonstances qui les déterminent[577]. »

Un effort concerté, soutenu et créatif des autorités fédérales, provinciales et territoriales est essentiel pour instiller ces principes dans les réformes législatives qui doivent être effectuées en matière de procréation médicalement assistée au Canada. Évidemment, l'élaboration d'objectifs publics et de normes médicales et bioéthiques nationales est aussi largement tributaire de l'intervention du secteur privé et des collectivités. Comment ce processus doit-il se dérouler ?

La Commission royale sur les nouvelles techniques de reproduction constitue un heureux début. Néanmoins, à de nombreux égards, l'intégration des efforts et des opinions pourrait fort bien exiger l'adoption d'une perspective aussi globale que celle qui a présidé à l'établissement au Canada du régime universel d'assurance-maladie il y a quelques années. En effet, si l'adoption d'une telle législation a réussi à modifier l'essence même des rapports entre les individus, les établissements hospitaliers et l'État dans la société canadienne, c'est grâce à une vue d'ensemble tenant compte à la fois du bien-être de l'individu, de la justice sociale et de la « coopération » nationale[578]. Reste à savoir si des changements d'une telle ampleur sont nécessaires[579]. En tout état de cause, c'est une collaboration

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576. Voir *supra*, p. 16 et suiv.

577. M. MINOW, *loc. cit.*, note 558, 23.

578. Voir le préambule de la *Loi canadienne sur la santé*, précitée, note 569.

579. Il semble que, même dans ce domaine important et délicat de la politique nationale, tout dépende en grande partie du consensus social sur la nécessité, la forme et le contenu des lois et politiques qui véhiculent les éléments de la justice en matière de procréation.

semblable entre le fédéral et les provinces qui est à l'origine de la politique nationale du Comité canadien du sang, de la création récente de l'Office canadien de coordination de l'évaluation des technologies de la santé[580] et du rôle joué par les comités nationaux d'experts dans l'élaboration des règlements fédéraux en matière d'environnement[581]. La Commission de réforme du droit de l'Ontario a d'ailleurs recommandé une telle collaboration[582]. Une même perspective et une même coopération fourniraient peut-être aujourd'hui aux législateurs et aux décideurs la clé d'une solution tout aussi efficace et adéquate aux défis que pose la procréation médicalement assistée.

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580. En ce sens, la prestation des services de procréation médicalement assistée au Canada pourrait notamment prendre pour modèle les services des transfusions sanguines. En effet, les Canadiens hospitalisés qui ont besoin de transfusions peuvent habituellement compter sur trois niveaux de coopération entre le fédéral et les provinces. Premièrement, l'hôpital ou la clinique où un patient est admis est vraisemblablement titulaire d'un permis qui lui a été délivré en vertu de la législation provinciale sur les établissements de santé et doit se conformer aux exigences de cette législation. Deuxièmement, pour assurer l'utilisation sans danger des réserves de sang du pays, les cliniques, les hôpitaux et les banques de sang du Canada doivent également respecter les normes minimales fédérales relatives au prélèvement, au tri, au traitement, au stockage, à l'expédition et à l'étiquetage des dérivés sanguins. Troisièmement, la gestion et l'élaboration des politiques et principes applicables à l'échelle nationale à l'égard des produits sanguins sont supervisées par le Comité canadien du sang. Voir CRD, *op. cit.*, note 254.

581. Voir la *Loi canadienne sur la protection de l'environnement*, L.C. 1988, ch. 22, art. 6, 34. « En vue d'établir un cadre d'action nationale et de prendre des mesures coordonnées dans les domaines touchant l'environnement, ainsi que pour éviter les conflits entre les règlements fédéraux et provinciaux ou leur dédoublement, le ministre peut, en collaboration avec les gouvernements provinciaux, constituer un comité consultatif fédéro-provincial chargé de le conseiller sur les projets de règlements » (art. 6). Voir également ENVIRONNEMENT CANADA, *Loi canadienne sur la protection de l'environnement : Rapport pour la période se terminant en mars 1990*, Ottawa, Approvisionnements et Services Canada, 1990, p. 11.

582. Voir CRDO, *op. cit.*, note 2, pp. 275, 277, rec. 2, 17.

CHAPITRE QUATRE

Recommandations

Nous avons déjà conclu, d'une part, qu'il y avait trop de risques à laisser l'application des différentes techniques de procréation médicalement assistée à l'initiative individuelle et, d'autre part, que les solutions de rechange envisagées étaient insuffisantes pour contrôler adéquatement les différents aspects de l'utilisation de ces techniques[583]. Nous devons donc considérer l'opportunité d'une intervention législative.

Le respect des valeurs fondamentales de notre société[584], la protection des citoyens contre les risques dont ils ne peuvent se protéger eux-mêmes et finalement la capacité des lois et des principes de droit de résoudre les conflits éventuels sont ici les principales considérations qui président à une telle intervention.

La Commission est consciente du fait que, en matière de procréation médicalement assistée, le droit provincial a un rôle très important à jouer. Toutefois, il nous apparaît essentiel de traiter le sujet sur un plan national et de façon globale. C'est dans cette optique qu'ont été formulées les recommandations qui suivent. Puisque la procréation médicalement assistée soulève, tant au niveau des principes qu'au niveau des normes d'application, des questions d'intérêt national, l'uniformité des politiques adoptées doit être fortement encouragée. Afin d'assurer la mise en œuvre et le respect de ces politiques à l'échelle nationale, nous devrons envisager l'opportunité de créer un organisme central qui remplirait ces fonctions.

Avant d'aborder les questions particulières, signalons tout d'abord qu'il existe des objections de principe à l'utilisation même des techniques de procréation médicalement assistée ou de certaines d'entre elles. Selon d'aucuns, la procréatique déshumaniserait la procréation, serait contre nature et constituerait une menace à la maternité et à la paternité

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583. Voir *supra*, ch. III.

584. *Les crimes contre le fœtus*, *op. cit.*, note 7, p. 33. *Id.*, p. 32 :

> Comme nous l'avons déjà fait remarquer, il est impossible de dégager des principes généraux à partir d'une doctrine religieuse ou d'un simple sondage d'opinion. Pour la Commission, la seule voie possible consiste à s'inspirer des valeurs fondamentales de notre société. Ces valeurs, comme nous le disions dans *Notre droit pénal*, se répartissent en deux catégories. Certaines sont nécessaires à l'existence même de toute société, alors que les autres sont propres au type de société qu'est la nôtre.
>
> Font partie de la première catégorie des valeurs telles que le respect de la vie et l'inviolabilité de la personne alors que la justice, l'égalité, la dignité et la liberté individuelle s'inscrivent dans la deuxième. Voir CRD, *Notre droit pénal*, Rapport n° 3, Ottawa, Approvisionnements et Services Canada, 1976, p. 21.

qui, dans cette perspective, sont inséparables de l'aspect procréateur de la sexualité[585]. De plus, le don de gamètes suscite des inquiétudes quant aux effets psychologiques néfastes que peut avoir sur l'enfant et le conjoint infertile l'intrusion d'une tierce personne dans la formation d'une unité familiale[586]. Comme nous l'avons souligné[587], la légitimité du don soulève également certaines interrogations. Ne s'agit-il pas d'« un déplacement de l'ordre des parentèles[588] » ? Enfin, certains soutiennent que l'embryon humain doit être traité avec le même respect et la même protection que la personne. Dans cette perspective, on dénonce la congélation et la destruction de l'embryon[589], ainsi que toute forme d'expérimentation. Ne faudrait-il pas même aller jusqu'à s'opposer à la création d'embryons surnuméraires ?

Pourtant, on ne saurait nier l'existence de ces techniques, ni le fait que, lorsque la procréation naturelle n'est pas possible ni souhaitable, il peut être moralement justifiable de mettre au point et d'appliquer des techniques pour remédier à l'infertilité.

Mais il est indispensable que notre société continue de s'interroger sur le traitement et la valeur à accorder aux gamètes et aux embryons humains. En matière de procréation médicalement assistée, cette réflexion doit se faire dans le cadre de la réalité médicale actuelle afin que puissent être appréciées les conséquences de tel ou tel choix. Prohiber la création d'embryons surnuméraires implique, par exemple, des conséquences pour la sécurité des femmes qui s'inscrivent à des programmes de fécondation in vitro. En effet, à chaque nouveau cycle, ces femmes se verraient forcées de s'exposer aux risques et inconvénients de la stimulation ovarienne et du prélèvement d'ovocytes, ou encore d'accepter le transfert d'un nombre plus élevé d'embryons, avec les dangers que cela comporte[590].

Cette réflexion doit également s'inscrire dans une perspective continue puisque l'élaboration d'une politique sur ces questions majeures demande une maîtrise des connaissances et un niveau de discussion qui évoluent en conséquence. Nous ne pouvons donc prétendre pouvoir fournir dans le présent document une réponse finale à cette réflexion sociale. Les objectifs que nous poursuivons sont, d'une part, de participer à cette discussion et, d'autre part, de composer avec la réalité actuelle afin de régler les problèmes urgents.

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585. Voir à ce sujet Pape Pie XII, *Discours aux participants au XXVI^e Congrès de la Société Italienne d'Urologie*, 8 octobre 1953 : AAS 45 (1953) 678 ; et plus récemment, CONGRÉGATION POUR LA DOCTRINE DE LA FOI, *op. cit.*, note 494.

586. L'objection la plus radicale vient ici du Vatican qui maintient que le recours aux gamètes d'une tierce personne « constitue une violation de l'engagement réciproque des époux et un manquement grave à l'unité, propriété essentielle du mariage. » Voir CONGRÉGATION POUR LA DOCTRINE DE LA FOI, *op. cit.*, note 494, p. 24.

587. Voir *supra*, p. 53 et suiv.

588. Voir M.-A. HERMITTE, *loc. cit.*, note 211, 337.

589. Une des objections du Vatican à la fécondation in vitro est basée sur le fait qu'elle peut impliquer la destruction de certains embryons. CONGRÉGATION POUR LA DOCTRINE DE LA FOI, *op. cit.*, note 494, p. 18.

590. D'autant plus que les techniques qui permettent d'éviter la stimulation ovarienne n'en sont encore aujourd'hui qu'au stade expérimental. Voir *supra*, p. 26.

La Commission a d'ailleurs déjà amorcé ce processus en publiant les documents *Les crimes contre le fœtus*[591] et *L'expérimentation biomédicale sur l'être humain*[592].

À cause du potentiel de vie et du génotype que présentent les gamètes et les embryons, la Commission leur a déjà reconnu une certaine valeur morale. Dans un premier temps, elle a fait valoir qu'il fallait différencier les gamètes et embryons des autres cellules et tissus humains : « Les premiers [gamètes] sont les sources virtuelles de nouvelles vies humaines ; les seconds [embryons] possèdent déjà la vie[593]. » De plus, dans les principes énoncés et les limites recommandées dans son document sur l'expérimentation[594], la Commission a consacré une valeur intrinsèque à l'embryon. Par exemple, elle a proposé que soit prohibée la création d'embryons aux seules fins de recherche scientifique[595], que le droit ne traite jamais les embryons comme de simples objets (leur commercialisation serait d'ailleurs résolument prohibée), que l'expérimentation soit interdite après le quatorzième jour du développement embryonnaire et que l'expérimentation soit préalablement autorisée par un comité d'éthique multidisciplinaire. La Commission est également d'avis que la façon la plus convenable de disposer des embryons surnuméraires résultant de la fécondation in vitro n'est pas leur destruction mais leur don à des couples infertiles ou, à défaut, l'expérimentation qui permet l'avancement des connaissances[596] ».

La protection de l'embryon ne s'oppose donc pas à la création d'embryons surnuméraires, à leur congélation ni à leur don. En fait, nous avons déjà recommandé de permettre la congélation d'embryons pour une période de cinq ans[597]. Et à ce stade, nous croyons qu'il convient de réitérer cette position. Sans consacrer leur légitimité, nous ne formulons aucune objection à l'égard de la création d'embryons surnuméraires, du don de gamètes et d'embryon, et de la congélation de ceux-ci.

I. Les principes généraux

La liberté individuelle, l'égalité et la dignité humaine[598] font partie des valeurs que mettent en présence les différentes questions que soulève la procréation médicalement assistée. Parmi ces questions, citons l'accès aux différentes techniques, les risques de dérive vers l'eugénisme, le phénomène de la maternité de substitution, la commercialisation et l'utilisation posthume des gamètes et des embryons, l'autorité sur ceux-ci, ainsi que la

591. *Op. cit.*, note 7.

592. *Op. cit.*, note 7.

593. *Id.*, p. 59.

594. Pour les différentes conditions juridiques imposées à la validité de l'expérimentation ainsi que les mécanismes prévus afin d'assurer le respect de ces principes, voir *id.*, rec. 6, p. 56.

595. Cette prohibition a d'ailleurs donné lieu à la recommandation d'une sanction criminelle : *id.*, rec. 7(1), p. 57.

596. *Id.*, p. 57 : « [S]i le don est impossible dans les circonstances, l'expérimentation pour permettre d'avancer les connaissances paraît, à prime abord, un choix préférable à la destruction pure et simple. »

597. *Id.*, rec. 8(2), p. 59.

598. Voir *Les crimes contre le fœtus*, *op. cit.*, note 7.

filiation des enfants nés de la procréatique. Pour les deux derniers points se pose en outre la question de l'application éventuelle, par nos tribunaux, des règles et des principes de droit existants. Quelles sont les valeurs qui doivent prévaloir ? Quels choix de société doivent guider le législateur ? Existe-t-il des compromis acceptables pour la société canadienne ? Comment faciliter la résolution des conflits engendrés par la technologie ? Telle est la nature des thèmes qui seront abordés ici.

A. L'accès

Plusieurs pays ont légiféré — ou ont proposé de le faire, dans des documents d'étude — pour limiter l'accès à la procréation médicalement assistée aux couples hétérosexuels stables qui sont stériles, infertiles ou porteurs d'affections génétiques transmissibles. L'intérêt de l'enfant (exprimé très souvent par son droit d'avoir un père, une mère, une famille stable) et l'intérêt social à protéger la cellule familiale, unité fondamentale de notre société, sont les deux principaux arguments généralement avancés en faveur d'une telle limitation.

Afin de déterminer l'opportunité de consacrer cette position dans un texte de loi, il importe d'analyser les critères susmentionnés en fonction, d'une part, des personnes susceptibles de demander une aide médicale et, d'autre part, des autres valeurs, principes et intérêts en cause. Dans la présente analyse, nous avons considéré le cas des personnes infertiles ou stériles (infertilité physiologique), celui des personnes qui sont incapables ou refusent de procréer dans le cadre d'une union hétérosexuelle (infertilité sociale) et finalement celui des personnes susceptibles de transmettre des affections d'ordre génétique (infertilité génétique)[599].

Les personnes atteintes d'infertilité physiologique sont celles qui ont le plus souvent recours aux techniques de procréation médicalement assistée. Généralement, les critères d'accès que l'on propose d'appliquer à ces personnes sont, d'une part, qu'elles soient parties à un couple hétérosexuel et, d'autre part, qu'elles soient stables. Il y a lieu de s'interroger sur l'à-propos de ces critères. Comme ceux de l'hétérosexualité et de l'état familial seront examinés plus loin dans le contexte de l'infertilité sociale, nous nous limiterons pour l'instant à celui de la *stabilité*.

Le critère de la stabilité, quoique attrayant, n'est pas sans soulever certaines difficultés. D'une part, est-il juste d'appliquer ce critère dans le contexte de l'insémination artificielle et de la fécondation in vitro alors que, en matière de procréation naturelle et de traitement hormonal ou chirurgical de l'infertilité (autres formes de procréation médicalement assistée),

599. Pour les fins de l'étude des critères limitatifs mentionnés ci-dessus, nous devons utiliser ici une définition de l'infertilité qui est plus large que celle utilisée dans le contexte médical (voir *supra*, ch. I). Cette approche vise à tenir compte non seulement de l'aspect pathologique mais également de la dimension sociale de l'infertilité. Voir à ce sujet THE NATIONAL BIOETHICS CONSULTATIVE COMMITTEE, *Discussion Paper on Access to Reproductive Technology*, Adelaïde, le Comité, 1990, p. 8 : [TRADUCTION]« Les croyances, les valeurs sociales, les attentes et les jugements de valeurs sont autant de facteurs qui contribuent à la définition sociale de l'infertilité et de la façon dont nous apprécions les moyens destinés à y remédier. »

la stabilité du couple et de la personne traitée n'entre pas en ligne de compte ? S'il est vrai que l'utilisation des gamètes provenant d'une tierce personne peut causer des difficultés particulières (divulgation des origines de l'enfant, etc.), nous croyons que le but visé par le critère de la stabilité, soit le bien-être de l'enfant, serait atteint plus facilement au moyen d'un soutien adéquat avant, pendant et après la conception[600]. D'autre part, ce critère est arbitraire, difficile à apprécier et, dans la mesure où il confie aux professionnels de la santé l'application de critères non médicaux, il ouvre la voie à la discrimination[601]. Il ne nous apparaît donc pas opportun de consacrer, dans un texte législatif, la stabilité comme critère déterminant en matière d'accès à la procréatique[602], pas plus d'ailleurs que n'importe quel autre critère reposant sur l'aptitude à être parent.

La situation des personnes physiologiquement et génétiquement aptes à procréer mais qui, pour des raisons personnelles, sont incapables ou refusent de le faire dans le cadre d'une union hétérosexuelle, est plus épineuse. Ces personnes peuvent être regroupées en deux catégories : les personnes vivant seules et les personnes homosexuelles. L'accès de ces personnes à la procréation médicalement assistée soulève toute la question du droit à l'égalité[603], par rapport à la protection de l'enfant et de la famille traditionnelle. Ainsi, l'État peut difficilement envisager d'assujettir l'accès à la procréation médicalement assistée à des limites législatives sans tenir compte des prescriptions et de l'esprit de la *Charte canadienne des droits et libertés*[604]. Pourtant, il suffit de consulter les différentes dispositions législatives et recommandations de divers pays pour constater que la situation de ces personnes est rarement considérée comme justifiant le recours à la procréation médicalement assistée. Plusieurs pays, en effet, exigent l'infertilité physiologique, la stérilité ou le risque de transmission d'affections génétiques comme condition d'accès à la procréatique, ou se contentent d'en restreindre tout simplement l'accès aux couples hétérosexuels[605].

Assujettir l'accès à la procréation médicalement assistée à différentes étiologies (stérilité, infertilité physiologique ou génétique) peut sembler normal puisque les techniques en cause ont été mises au point précisément pour remédier à ces problèmes. Toutefois,

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600. Voir *infra*, p. 167 et suiv.

601. Voir Benjamin FREEDMAN, P.J. TAYLOR, Thomas WONNACOTT et Katherine HILL, « Criteria for Parenting in Canada: A Comparative Survey of Adoption and Artificial Insemination Practices » (1988), 3 *C.F.L.Q.* 35. Cet article est le fruit d'une étude parrainée par les Subventions stratégiques de recherche sur la science, la technologie et les valeurs humaines du Conseil de recherches en sciences humaines du Canada. Voir *id.*, 36-37.

602. Signalons toutefois que dans certains rapports on a adopté une position contraire ; à titre d'exemple, voir CRDO, *op. cit.*, note 2, rec. 5, p. 275 : [TRADUCTION] « L'admissibilité aux programmes de conception médicalement assistée devrait être limitée aux femmes célibataires stables, et aux hommes et femmes stables formant un couple stable, mariés ou non. » Le rapport du BARREAU DU QUÉBEC, *loc. cit.*, note 3, p. 36, recommande que l'accès soit réservé aux couples stables, mariés ou non ; pour plus de détails, voir *infra*, annexe A, 1 pp. 187-188.

603. Voir la rubrique « L'article 15 : les droits à l'égalité », *supra*, p. 101 et suiv., plus particulièrement la p. 106.

604. Voir *supra*, pp. 90, 97-99, 103, 107-108.

605. Voir *infra*, annexe A, pp. 187-188.

nous devons nous rappeler que l'établissement de telles restrictions en matière d'insémination artificielle[606] aurait pour effet de rendre la procréatique inaccessible aux personnes seules et aux personnes homosexuelles[607].

C'est donc la question de l'accès non discriminatoire à la technologie médicale disponible qui se pose. Elle met en présence, d'une part, l'intérêt des personnes seules ou homosexuelles qui expriment le désir d'avoir un enfant et de recourir, au même titre que les personnes infertiles ou stériles parties à une union hétérosexuelle, à la technologie disponible pour surmonter les obstacles à la réalisation de ce désir et, d'autre part, l'intérêt de l'enfant et de la société dans la protection de la famille biparentale hétérosexuelle.

Le conflit entre le respect des droits garantis par la Charte et la protection de la famille traditionnelle nous ramène à des interrogations fondamentales. Jusqu'où voulons-nous aller dans la protection des droits et libertés et plus particulièrement du droit à l'égalité ? Jusqu'où voulons-nous étendre la définition de la famille ? Voulons-nous y inclure la famille homosexuelle et la famille monoparentale ?

Pour certains, l'intérêt de l'enfant et l'importance que revêt la famille biparentale hétérosexuelle pour la société doivent avoir préséance sur les droits des personnes seules ou homosexuelles. Suivant cette position, avoir la liberté de choisir son orientation sexuelle est une chose, priver un enfant d'un père ou d'une mère en est une autre. La procréatique doit demeurer un palliatif à l'infertilité (physiologique ou génétique) et non devenir une solution de convenance destinée à éluder les conséquences d'un choix social.

Pour d'autres, qui font l'analogie avec les critères d'accès à l'adoption, ces oppositions sont l'expression de préjugés dépassés[608]. De plus, au fil des ans, l'État s'est abstenu d'intervenir pour protéger la famille traditionnelle dont la structure s'est considérablement effritée[609].

La réponse à la question de l'accès à la procréation médicalement assistée suppose donc une réflexion fondamentale sur le devenir de la famille à l'aube du XXI[e] siècle.

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606. Nous avons déjà mentionné que la situation est différente en matière de fécondation in vitro. La fécondation in vitro et ses dérivés, contrairement à l'insémination artificielle, vise principalement l'infertilité de la femme. Voir *supra*, p. 107.

607. La limitation législative de l'accès ne doit pas créer de disparités à l'égard des groupes visés à l'art. 15 de la Charte et des groupes analogues. Voir la rubrique « L'article 15 : les droits à l'égalité », *supra*, p. 101 et suiv., plus particulièrement la p. 103.

608. Voir *supra*, pp. 107-108 ; B.M. KNOPPERS, *loc. cit.*, note 287, 216, [TRADUCTION] « Il est assez ironique que, à une époque où on s'emploie à assouplir les lois sur l'adoption afin de permettre aux personnes célibataires des deux sexes d'élever des enfants, les préjugés sociaux empêchent les femmes célibataires de recourir à des techniques qui leur permettraient de porter et de mettre au monde des enfants qui, dans certains cas, leur seraient génétiquement liés, du moins pour moitié. » Voir également *supra*, notes 470-471.

609. Dans le domaine des relations de travail, une décision récente de la Cour fédérale d'appel a toutefois renversé la décision d'un tribunal canadien des droits de la personne qui avait pour effet d'élargir la définition de famille pour y inclure le couple homosexuel. Cette décision faisait suite à une plainte déposée en application de la *Loi canadienne sur les droits de la personne*, précitée, note 458. Voir l'arrêt *Mossop*, précité, note 462. À la p. 35 du jugement en appel : « Même si nous devions convenir que deux amants homosexuels peuvent constituer "sociologiquement parlant" une sorte de famille, ce n'est certainement pas une famille qui, juridiquement parlant, confère à ses membres des obligations et des droits spéciaux. »

Sommes-nous prêts non seulement à accepter mais à mettre au même rang de nos valeurs sociales la famille biparentale hétérosexuelle, la famille biparentale homosexuelle et la famille monoparentale ? Dans l'affirmative, ne devrions-nous pas, afin d'être constants dans nos choix, modifier toute la législation qui concerne la famille pour y intégrer ces nouvelles définitions ? Ou voulons-nous, au contraire, associer la protection de la famille traditionnelle à l'intérêt public pour lui donner préséance sur les droits et libertés garantis par la Charte et limiter ainsi le droit de procréer, comme nous limitons d'ailleurs le droit de se marier dans notre société ? Cette réflexion pourrait s'inspirer de situations analogues en matière de procréation « naturelle », où les familles biparentales homosexuelles et monoparentales font partie de la réalité.

Pour l'instant, compte tenu de la réalité sociale actuelle, la Commission est d'avis que, en matière d'accès à l'insémination artificielle, il n'y a pas lieu, dans un texte de loi, de protéger la famille traditionnelle au détriment du respect du droit à l'égalité[610]. De plus, vu la nature de l'insémination artificielle, nous considérons que l'intervention de l'État dans ce domaine doit être minimale[611]. En matière de fécondation in vitro, rappelons que la question du droit à l'égalité soulève peu de difficultés[612]. D'autre part, comme la procréatique met en jeu l'allocation de ressources rares et coûteuses, la limitation législative de l'accès pourrait s'avérer nécessaire. Quoi qu'il en soit, une telle intervention devrait, par souci de prudence, se faire dans le respect des principes de justice fondamentale[613].

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610. Le Cortès espagnol a adopté une loi sur la procréatique qui ne limite pas l'accès à celle-ci aux couples mariés. Les femmes seules ou vivant maritalement sont admissibles. Voir *infra*, annexe A, pp. 187-188. CRDO, *op. cit.*, note 2, p. 157 : [TRADUCTION] « [L]a majorité des commissaires en sont venus à la conclusion que, même si la conception artificielle ne doit pas être mise à la disposition de toute personne infertile ou porteuse d'une affection génétique, il n'y a pas lieu non plus de restreindre l'admissibilité aux couples mariés, ni même aux couples. » La CRDO précise dans sa première recommandation (p. 275) que les techniques ne doivent être utilisées que pour des raisons médicales, sauf lorsqu'il s'agit d'une femme célibataire fertile et génétiquement saine. Le rapport du MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX, *op. cit.*, note 508, art. 11, p. 176, précise que l'insémination artificielle doit être accessible aux femmes seules, quel que soit leur statut. ASSOCIATION DU BARREAU CANADIEN, *op. cit.*, note 281, p. 22 : [TRADUCTION] « Après de longues discussions, le Comité a conclu qu'il n'était pas nécessaire d'établir les critères d'admissibilité par la voie législative. Bien que cette solution puisse avoir pour effet de laisser le patient à la merci des préjugés du médecin traitant, le Comité estime que la législation actuelle touchant les procédés discriminatoires constitue une protection suffisante. » En Suède, par contre, ces techniques sont réservées aux couples mariés ou vivant maritalement et le consentement du mari est exigé ; voir *infra*, annexe A, pp. 187-188 à la note 55. En Norvège, le Parlement a adopté une loi réglementant l'insémination artificielle et la fécondation in vitro qui limite l'accès aux couples mariés qui ont donné leur consentement et qui se sont soumis à une évaluation médicale et psychosociale exécutée par un médecin ; voir *infra*, annexe A, pp. 187-188 à la note 56. CONSEIL DE L'EUROPE, *Procréation artificielle humaine*, Strasbourg, le Conseil, 1989, p. 18 :

> Après avoir examiné soigneusement ces arguments — en particulier la nature médicale de ces techniques — et en tenant compte de l'importance de la nécessité d'assurer le bien-être de l'enfant à naître, le comité est arrivé à la conclusion que l'emploi de techniques de procréation artificielle devrait être limité aux seuls couples hétérosexuels ayant besoin d'une aide médicale. Cette approche vise à éliminer les cas dans lesquels l'enfant à naître serait inévitablement « orphelin ».

Pour plus de détails concernant la position d'autres pays et États, voir *infra*, annexe A, pp. 187-188. Pour les rapports qui ont limité l'accès aux individus infertiles et à ceux qui courraient le risque de transmettre des affections génétiques à leurs enfants, voir *infra*, annexe A, pp. 188-189.

611. Voir *supra*, p. 99.

612. Voir *supra*, p. 107.

613. Voir à ce sujet, *supra*, p. 98 et suiv.

Enfin, l'admissibilité de la personne physiologiquement apte à procréer mais porteuse d'une affection génétique implique des choix quant aux types d'affections justifiant le recours à la procréatique, et quant aux gamètes et aux embryons devant être tenus pour « acceptables ». Or ces choix laissent entrevoir le spectre de l'eugénisme et appellent également une autre question, celle de la sélection des donneurs ou de leurs caractéristiques.

D'autre part, le recours aux techniques de procréation médicalement assistée pour éviter la transmission d'une prédisposition génétique ou d'un trait caractéristique jugés indésirables[614], ou encore pour choisir le sexe ou les caractéristiques de l'enfant à naître, paraît inacceptable[615]. Sur une vaste échelle, de telles pratiques pourraient encourager le développement d'un trafic de gamètes et d'embryons présentant des qualités particulières[616], nourrir l'intolérance face à l'imperfection humaine et compromettre l'équilibre démographique et social entre les sexes pour les générations à venir, sans parler des conséquences que pourraient subir ces enfants « sur mesure ». Dans ce contexte, il paraît donc opportun de restreindre de façon générale les libertés individuelles au nom du respect de la dignité humaine.

Quels types d'affections génétiques justifient le recours à la procréation médicalement assistée ? Il est possible de répondre indirectement à cette question en ne permettant la sélection des gamètes et des embryons que lorsqu'il s'agit d'éviter la transmission d'une maladie génétique grave. La limitation du choix du donneur et de ses caractéristiques contribuerait également à décourager le recours injustifié à la procréatique.

C'est une chose de permettre au corps médical de répondre, dans la mesure du possible, aux inquiétudes des couples à propos de l'homogénéité de la cellule familiale. C'en est une autre que de permettre à ceux-ci de choisir tel ou tel donneur en raison de ses diverses caractéristiques, ou d'exiger que les gamètes ou embryons fassent l'objet de manipulations génétiques afin que l'enfant réponde à leurs caprices ou aux stéréotypes de la société, il y a un pas énorme que la Commission n'est pas près de franchir[617]. Il est donc important que la description des caractéristiques du donneur, de ses gamètes et des embryons qui

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614. Le trait caractéristique s'oppose aux maladies génétiques graves telles que la maladie de Tay-Sachs, la thalassémie, la myopathie de Duchenne, l'hémophilie, la chorée de Huntington.

615. C. OVERALL, « Introduction », dans C. OVERALL (dir.), *op. cit.*, note 130, p. 1, à la page 18 :

> [TRADUCTION]
> L'avènement de la procréatique aura eu pour conséquence de nous permettre de décider de manière de plus en plus détaillée du genre d'enfants que nous voulons ou ne voulons pas avoir. La réalisation du désir en apparence innocent et louable de mettre au monde des enfants robustes et en bonne santé emporte celle du désir moins louable d'empêcher la naissance d'enfants affublés de traits caractéristiques soi-disant indésirables.

Voir *infra*, annexe A, pp. 188-189.

616. Le Repository for Germinal Choice en Californie, autrement connu sous le nom de « Nobel Prize sperm bank » est un exemple. Voir Arthur CAPLAN, « California Sperm Bank is a Loony Notion » *The [Montreal] Gazette* (24 novembre 1989) B-3 : [TRADUCTION] « Cette banque se targue d'avoir dans ses frigos des dépôts provenant d'éminents scientifiques, de génies de la finance et d'au moins un athlète olympique. Plus de 100 bébés ont été conçus grâce à du sperme provenant du Repository for Germinal Choice. Les couples qui désirent faire appel à cet organisme doivent être mariés et doivent faire la preuve de leurs aptitudes et de leur prospérité. »

617. Voir *infra*, annexe A, pp. 188-189.

en sont issus soit limitée à ce qui est strictement nécessaire pour éviter la transmission d'une maladie génétique grave[618]. Par exemple, la possibilité de choisir le sexe de l'enfant pourrait être acceptable lorsqu'il s'agit d'empêcher la transmission d'une maladie génétique liée au sexe telle l'hémophilie.

Le respect de ces limites dépend du contrôle qui s'exercera sur l'activité des banques de gamètes et des cliniques d'infertilité, et sur l'importation des gamètes. Et pour être efficaces, ces limites devront également recevoir une application uniforme partout au Canada.

RECOMMANDATIONS

1. L'intervention éventuelle du législateur pour régir l'accès aux techniques de procréation médicalement assistée devrait respecter le droit à l'égalité. L'accès ne devrait être limité qu'en fonction du coût et de la rareté des ressources. Le cas échéant, la sélection ne pourrait reposer sur des motifs de discrimination illicites aux termes des législations fédérale et provinciales (la situation de famille, l'état matrimonial, l'orientation sexuelle, etc.).

2. Afin d'éviter de donner prise à l'eugénisme, la sélection des gamètes et des embryons en fonction de qualités particulières devrait être prohibée sauf lorsqu'elle a pour but d'éviter la transmission de maladies génétiques graves.

B. La commercialisation

L'existence d'embryons surnuméraires et le don, la conservation et l'importation de gamètes et d'embryons sont autant de facteurs qui rendent alléchante la possibilité de considérer ceux-ci comme des choses pouvant faire l'objet d'un commerce[619]. Ils posent à la société la question même de leur nature et celle d'une nouvelle définition de la personne en droit, à savoir ce qui peut faire l'objet d'un commerce, ou ce qui peut être « réifié[620] ».

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618. Voir le rapport du MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX DU QUÉBEC, *op. cit.*, note 508, p. 65 ; voir également *infra*, annexe A, p. 189.

619. Voir *supra*, p. 47.

620. Bernard KEATING, *Le statut moral de l'embryon humain : une approche attentive à la question des fondements de l'éthique*, thèse de doctorat, Québec, École des gradués de l'Université Laval, 1990, pp. 138-140 :

> S'interroger sur le statut de l'embryon humain, c'est se demander où tracer la ligne de démarcation qui sépare les personnes des choses. Cette décision est capitale : on dispose des choses, on respecte les personnes. Les choses ont un prix, les personnes sont au-dessus de tout prix. Faire de l'embryon une personne, c'est donc accepter de reconnaître des limites à notre faculté d'agir, à son endroit, comme bon nous semble. La personne, on le sait, ne peut jamais être un simple moyen au service de nos fins. L'enjeu est de taille. [...] Accepter de traiter la vie humaine, dans l'obscurité de ses débuts, comme un objet n'implique-t-il pas d'avoir déjà accepté un respect relatif de la personne ?

La médecine moderne a donné une dimension nouvelle[621] à la commercialisation du corps humain, de ses produits et de ses substances. Il suffit de penser à l'affaire américaine *Moore* c. *Regents of the University of California*[622] pour comprendre la complexité des problèmes qui en résultent[623].

La particularité des gamètes et embryons, signalée d'ailleurs par la Conférence sur l'uniformisation des lois au Canada qui les exclut de sa définition du terme « tissu[624] », soulève plusieurs interrogations. Si leur nature et leur utilisation mettent en cause la dignité humaine et nous amènent à nous interroger sur la valeur morale ou symbolique à leur accorder, ainsi que sur la réification de l'être humain, la commercialisation des gamètes et des embryons pose un problème parallèle de sécurité tant pour la femme chez qui ils seront implantés que pour l'enfant à naître. Enfin, elle touche à la liberté du commerce.

1. L'embryon

La commercialisation de l'embryon doit être complètement prohibée ici comme en matière d'expérimentation[625]. C'est en effet attaquer directement la dignité humaine que

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621. Sur la question de la commercialisation des organes humains, voir *Prélèvement et utilisation médicale de tissus et d'organes humaines*, *op. cit.*, note 254.

622. 249 Cal. Rptr 494, 498, 504 (App. 2d Dist. 1988) :

> [TRADUCTION]
>
> Le présent appel soulève des questions fondamentales au sujet du droit du patient de disposer de son propre corps, dont celle de savoir si l'exploitation commerciale des cellules du patient par des professionnels de la santé, sans le consentement de celui-ci, peut donner lieu à une action en dommages-intérêts. Cette affaire est sans précédent [...]
>
> Nous avons abordé cette question avec circonspection. Notre civilisation en est venue à abandonner l'esclavage au profit de la liberté, à cesser de considérer l'être humain comme un bien pour reconnaître la dignité individuelle de chacun. Aussi faut-il faire preuve de beaucoup de prudence au moment d'attribuer aux tissus humains les caractéristiques d'un bien susceptible d'appropriation. Cela dit, il existe une différence fondamentale entre le fait d'exercer des droits de propriété sur son propre corps et le fait d'être la propriété de quelqu'un d'autre [...] Il ne s'agit pas pour nous de décider si l'utilisation de tissus humains ou de parties du corps devrait toujours se faire à titre gratuit ou si elle peut faire l'objet d'un commerce obéissant aux lois du marché. C'est là une question de politique qui ressortit au législateur. En l'espèce, les défendeurs ont déjà amorcé la mise en marché de la lignée cellulaire, ce qui nous place devant le fait accompli et nous laisse à décider qui doit participer aux profits.

Cette décision a été confirmée en partie par 793 P. 2d 479 (Cal. 1990). La partie du jugement qui traite du principe général reconnaissant les droits du patient sur son propre corps a été confirmée. Les bases de ce principe ont cependant été restreintes au principe du consentement éclairé et à la nature de la relation patient-médecin. Pour plus de détails, voir *Prélèvement et utilisation médicale de tissus et d'organes humains*, *op. cit.*, note 254.

623. La pensée juridique sur le sujet est présentement en plein essor et la diversité des solutions proposées démontre qu'elle doit continuer de se développer. À titre d'exemple, mentionnons la théorie de l'affectation de Jean-Christophe GALLOUX, « De la nature juridique du matériel génétique ou la réification du corps humain et du vivant » (1989), 3 *R. recherche jur.* 1, 1-31, qui implique une notion absolue mais fonctionnelle d'extra-commercialité du corps humain. Hermitte, pour sa part, conclut qu'une nouvelle catégorie est nécessaire, et propose la catégorie de la « chose d'origine humaine et à finalité humaine » qu'elle subdivise, en fonction du produit du corps humain, en « produits hors commerce », « hors de tout échange », « dans l'échange rémunéré » et « dans le marché », etc. ; *loc. cit.*, note 211, 325.

624. *Loi uniforme sur le don de tissus humains*, 1989, précitée, note 240, art. 1 ; voir *supra*, note 241. Voir aussi l'opinion de la Commission déjà mentionnée, *supra*, p. 133.

625. *L'expérimentation biomédicale sur l'être humain*, *op. cit.*, note 7, p. 54.

de traiter l'embryon comme une chose pouvant faire l'objet d'un commerce, d'en faire un produit de consommation[626]. Si l'embryon peut faire l'objet d'un certain nombre d'opérations juridiques, nous devons nous assurer qu'il ne sera pas mis sur le marché, à la merci des lois de l'offre et de la demande[627].

2. Les gamètes

La réduction des gamètes à de simples produits de consommation risque elle aussi de contrevenir à la notion fondamentale de dignité humaine. D'une part, la nature particulière des gamètes en tant que sources de vie et le but visé par le don (permettre aux personnes infertiles de réaliser un projet parental) se prêtent mal au commerce dans notre société. Le don de gamètes doit demeurer un acte altruiste. D'autre part, la concurrence entre les banques pourrait conduire à certaines formes d'eugénisme. Par exemple, les banques risquent de ne vouloir attirer et accepter que les donneurs qui possèdent certaines qualités ou caractéristiques jugées plus désirables, se faisant ainsi l'écho d'un stéréotype commercial du mâle géniteur[628]. Dans ces conditions, les donneurs pourraient être rémunérés en fonction de leurs caractéristiques. Et même s'il était impossible au couple de choisir les caractéristiques de l'enfant désiré, la réputation de telle ou telle banque pour la « qualité » de ses donneurs risque d'avoir le même résultat : la mise en place d'une forme d'eugénisme[629].

Par ailleurs, la commercialisation du don de gamètes risque de compromettre la « qualité » des gamètes utilisés. En effet, l'appât du gain pourrait inciter les donneurs à retenir certains renseignements essentiels[630]. D'autre part, le désir des banques d'accroître leurs profits pourrait amener celles-ci à sacrifier la sélection et le dépistage médicaux.

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626. *Ibid.*

627. Voir Evelyne SHUSTER, « Seven Embryos in Search of Legitimacy » (1990), 53:6 *Fertil. Steril.* 975, 977 :

> [TRADUCTION]
> [S]uivant la position dominante, le droit de l'embryon à la vie est de nature particulière ou limitée. Celui-ci ne saurait donc être traité comme une personne véritable investie de droits moraux complets. En revanche, comme il s'agit d'une personne potentielle, il s'apparente au sujet de droit et non à l'objet : il n'est ni une chose ni un bien, il ne peut être ni vendu, ni acheté, ni retourné. Il ne peut faire l'objet d'un droit de propriété qui permettrait au titulaire d'en disposer à sa guise.

628. COUNCIL FOR SCIENCE AND SOCIETY, *op. cit.*, note 537, pp. 41-42, n° 4.8 :

> [TRADUCTION]
> L'instauration de banques commerciales (comme cela s'est déjà produit aux États-Unis) pourrait ouvrir la voie à des procédés répréhensibles. Le donneur aux caractéristiques « désirables » pourrait bien être tenté de vendre sa semence à prix d'or. Aux États-Unis, on offre déjà, à grand renfort de publicité, le sperme de récipiendaires du prix Nobel, flattant ainsi le désir des couples de mettre au monde de futurs génies, mais passant sous silence les risques que comporte l'utilisation du sperme d'hommes vieillissants.

629. *L'expérimentation biomédicale sur l'être humain*, *op. cit.*, note 7, p. 59 : « La Commission est d'avis que de nouvelles recommandations concernant non seulement les banques de sperme, mais aussi les banques d'embryons, devraient être formulées de façon à établir des normes claires et précises, et à prévenir les inconvénients et dangers d'une expansion et d'une commercialisation anarchiques de ces banques. »

630. CRDO, *op. cit.*, note 2, p. 169 :

> [TRADUCTION]
> [E]n outre, la nécessité de renseignements solides sur les antécédents familiaux du donneur et sur la possibilité qu'il ait pu contracter une maladie transmissible sexuellement entre le moment

Ainsi, l'atteinte à la dignité humaine et les risques qu'implique la commercialisation justifient la limitation des libertés individuelles, notamment la liberté du commerce. En revanche, ce serait pousser les choses à l'extrême et décourager les donneurs que d'interdire le remboursement des frais raisonnables engagés par ces derniers[631].

Enfin, puisqu'il faut assurer la qualité maximale de la sélection et du dépistage génétique, les banques devraient pouvoir se faire rembourser les frais raisonnables afférents à leurs activités[632].

RECOMMANDATION

3. (1) La commercialisation du don de gamètes ou d'embryon devrait être interdite. Seul le remboursement des frais raisonnables engagés par le donneur devrait être autorisé.

(2) Il devrait être interdit aux banques de gamètes ou d'embryons d'exercer leurs activités dans un but lucratif. Toutefois, les banques devraient pouvoir se faire rembourser les frais raisonnables afférents à leurs activités et à leur fonctionnement.

C. La maternité de substitution

Soulignons d'entrée de jeu que l'importance du phénomène des femmes porteuses est très difficile à apprécier. Les auteures d'une étude menée pour la Commission de réforme du droit du Canada en 1988 sur les pratiques en cette matière concluaient :

> La grande conclusion qui se dégage de notre étude est celle-ci : les contrats de grossesse constituent un phénomène relativement peu répandu, mais néanmoins beaucoup plus fréquent que l'estimaient — à une exception près — les personnes à qui nous avons parlé et qui se disaient bien renseignées. Notre estimation globale inférieure (attribution de 11 cas seulement pour le Québec) nous donne un total de 104 cas pour tout le Canada ; tandis qu'avec l'estimation supérieure (25 cas pour le Québec), le total est de 118.

> du dépistage génétique initial et celui du prélèvement nous force à conclure que le don de gamètes ne devrait pas devenir un geste lucratif qui inciterait les donneurs à taire des renseignements importants. Les risques de réticences et le prix que devront payer ceux qui devront en assumer les conséquences sont trop élevés par rapport aux avantages que pourrait présenter la rémunération illimitée.
>
> En conséquence, la Commission recommande que les donneurs individuels aient le droit de recouvrer les frais raisonnables qu'ils ont engagés.

Voir également *id.*, rec. 15, p. 276.

631. Dans le même sens, voir *infra*, annexe A, notes 65 et 66, p. 190. Voir aussi la loi modifiant la loi uniforme sur le statut de l'enfant, précitée, note 203, art. 11.5 ; voir *supra*, note 256.

632. Voir dans ce sens, *infra*, annexe A, note 67, p. 190. Toutefois, selon la CRDO, *op. cit.*, note 2, p. 172, les banques pourraient légitimement réaliser certains profits ; voir *infra*, annexe A, p. 190.

> Or, ces deux chiffres dépassent de loin les estimations qu'on nous avait données comme raisonnables, au chapitre de la fréquence globale. Il importe à cet égard de rappeler l'extrême rigueur dont nous avons fait preuve dans notre calcul, tous les cas le moindrement douteux ayant été exclus. Nous sommes donc persuadées que nos chiffres correspondent à une estimation très prudente, probablement inférieure de beaucoup à la véritable fréquence du phénomène.
>
> Nous avons également effectué une analyse des caractéristiques socio-économiques des mères porteuses, des pères et de leurs femmes, sur la base des données fournies par les agences de Noel Keane. Globalement, les mères biologiques appartiennent à une classe sociale inférieure que les pères et leurs épouses. Rien ne nous autorise cependant à penser que c'est aussi le cas pour les personnes qui concluent des contrats informels. Nous ne disposons pas de renseignements suffisants pour faire des hypothèses sérieuses sur les caractéristiques socio-économiques de ces personnes.[633]

Abstraction faite de ses aspects contractuel[634] et commercial, la maternité de substitution prête à de nombreuses controverses. D'une part, l'incertitude qui entoure ses répercussions sur les parties intéressées — notamment la femme porteuse et surtout l'enfant à naître — suscite des inquiétudes importantes quant aux risques psychologiques possibles[635]. Le fait que la femme porteuse soit une parente ou une amie de la famille paraît atténuer la répugnance que suscite cette technique chez certains, mais n'en supprime pas les effets pour autant. Les liens qui unissent les parties pourraient éventuellement compliquer encore davantage la situation. D'autre part, l'enfant peut également se voir exposé à des risques physiques importants si la femme porteuse, sachant qu'elle doit rendre l'enfant à la naissance, se montre négligente et ne prend pas les précautions nécessaires à la création d'un environnement sain, essentiel au développement normal du fœtus.

Mais au-delà de ces questions de sécurité, d'aucuns considèrent que le phénomène contrevient aux valeurs fondamentales de notre société, notamment la dignité humaine et la protection de la famille traditionnelle[636]. On soutient que le recours à une femme porteuse déshumanise la maternité, dévalorise la gestation[637], porte atteinte au droit de l'enfant de ne pas être traité comme une chose pouvant faire l'objet d'un contrat. La conception intentionnelle d'un enfant dans le but de le rendre à une tierce personne à la naissance témoigne d'un manque de respect envers l'enfant à naître et la vie elle-même. Au nom de ces intérêts supérieurs, certains diront que les libertés individuelles devraient être limitées et la maternité de substitution prohibée sous toutes ses formes.

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633. M. Eichler et P. Poole, *op. cit.*, note 534, pp. 55-56. Cette étude démontre très clairement, à tout le moins, qu'il s'agit d'un phénomène clandestin, extrêmement difficile à apprécier ; elle contient une série de tableaux fort intéressants, en appendice.

634. Nous avons vu au chapitre II que, dans l'état actuel du droit, l'aspect contractuel de la maternité de substitution déroge aux principes du droit des contrats et du droit de la famille ; voir *supra*, les rubriques « La légalité et la légitimité », p. 73 et « La force exécutoire du contrat de maternité de substitution », p. 93.

635. Ces arguments ont été exposés par la CRDO, *op. cit.*, note 2, p. 230. Voir également Barreau du Québec, *loc. cit.*, note 3, 28 et Rapport Warnock, *op. cit.*, note 425, pp. 73-74.

636. À titre d'exemple, voir Barreau du Québec, *loc. cit.*, note 3, 28 ; voir également A.M. Capron et M.J. Radin, « Choosing Family Law over Contract Law as a Paradigm for Surrogate Motherhood » (1988), 16:1-2 *Law Med. Health Care* 34, 36-37.

637. J.-L. Baudouin et C. Labrusse-Riou, *op. cit.*, note 214, p. 111 : « La gestation ne constitue plus ainsi une étape dans l'établissement d'une relation permanente mère-enfant. Elle devient une simple fonction temporaire de fabrication. Elle ne sert pas à la création d'un lien affectif, mais est utilisée comme simple support technique. » Voir Barreau du Québec, *loc. cit.*, note 3, 29.

Pour d'autres, les risques psychologiques, quoique sérieux, sont du domaine de la spéculation dans l'état actuel des connaissances sur la nature réelle du lien qui s'établit au cours de la gestation[638]. Cet aspect ne saurait donc motiver une interdiction. Les risques physiologiques, pour leur part, pourraient être réduits grâce à une surveillance médicale adéquate[639] — éventuellement obligatoire — de la femme porteuse. En ce qui a trait aux risques pour l'institution de la famille, tous ne sont pas convaincus que l'intervention d'une femme porteuse représente une atteinte dommageable[640].

Même si nous ne sommes pas en mesure d'apprécier les effets psychologiques de la maternité de substitution, nul n'est besoin de procéder à une étude exhaustive pour conclure que la prudence est ici de rigueur. Si la réglementation peut diminuer les risques physiologiques, elle suppose l'aval de l'État et la légitimation du contrat d'« enfantement[641] ». Or, comme nous l'avons déjà souligné[642], ce contrat déroge à un principe fondamental du droit de la famille : la garde de l'enfant doit être décidée en fonction de l'intérêt véritable de celui-ci, et non de la volonté des parents exprimée dans un contrat.

Le principe de la dignité humaine nous amène à conclure que l'enfant ne peut faire l'objet d'un tel contrat et ne doit d'aucune façon être traité comme une chose[643]. Et ce principe devrait avoir préséance sur les libertés individuelles. Traiter l'enfant autrement risquerait de changer notre vision de l'humain. Il est important que le législateur intervienne à l'échelle nationale pour affirmer sans équivoque cette valeur fondamentale et pour décourager toute activité liée à la maternité de substitution[644]. Dans cette optique, l'entente de maternité de substitution ne devrait en aucun cas être reconnue en droit ; elle doit

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638. Voir CRDO, *op. cit.*, note 2, p. 231.

639. *Ibid.*

640. *Id.*, p. 232. Voir également ASSOCIATION DU BARREAU CANADIEN, *op. cit.*, note 281, p. 28 : [TRADUCTION] « On n'a pas convaincu le Comité que la reconnaissance du contrat de maternité de substitution viendrait saper les bases de la structure familiale actuelle ».

641. Voir Rapport Warnock, *op. cit.*, note 425, pp. 75-77.

642. Voir *supra*, note 634.

643. Voir *supra*, pp. 47-48 et en particulier la note 213.

644. R. Alta CHARO, « Reproductive Technologies and Bioethics in the United States: Looking Back, Looking Ahead », dans Christian BYK, (dir.), *Procréation artificielle : Où en sont l'éthique et le droit ?*, Lyon, Lacassagne, 1989, p. 249, à la page 255 : [TRADUCTION] « En fait, à la suite de la controverse suscitée par l'affaire *Baby M*, la tendance législative aux États-Unis a semblé changer. De la relative réceptivité des premières lois de l'Arkansas, du Kansas et du Nevada, qui avaient eu pour effet de légitimer certaines parties de l'opération sans toutefois consacrer celle-ci ni reconnaître la validité du contrat, cette tendance est passée à l'interdiction. » THE NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, *Surrogate Parenting: Analysis and Recommendations for Public Policy*, New York, the Task Force, 1988, p. 127 :

> [TRADUCTION]
> Étant donné les risques qui menacent les enfants nés de la maternité de substitution, il est dans l'intérêt de ceux-ci de décourager cette technique.
>
> Les membres du Groupe de travail ont beaucoup de sympathie pour les couples infertiles qui, dans bien des cas, éprouvent une vive sensation de vide et de détresse. Ils concluent néanmoins que la société ne devrait pas retenir la maternité de substitution comme solution. Cette technique risque de causer des problèmes et des malaises sociaux bien plus graves que ceux des couples infertiles qui cherchent à y recourir.

demeurer nulle de nullité absolue[645]. Cette conclusion est conforme aux principes du droit des contrats et du droit de la famille. L'intérêt de l'enfant doit demeurer la base décisionnelle en matière de garde, et la liberté contractuelle doit être limitée en conséquence[646].

L'aspect commercial de l'entente de maternité de substitution pose à la société diverses questions. Pour certains, le « louage d'utérus » constitue un affront à la dignité et à l'intégrité de l'être humain[647]. D'autres évoquent la possibilité de l'exploitation des femmes moins favorisées par celles qui détiennent un certain pouvoir économique. Ce type d'entente est aussi perçu comme dégradant pour l'enfant qui est échangé contre une somme d'argent et réduit à un simple objet. Mettre une valeur vénale sur un enfant cause un préjudice non seulement à ce dernier mais aussi à la société. L'aspect commercial de la maternité de substitution constitue un outrage à une autre valeur fondamentale : l'être humain est hors du commerce[648].

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645. Au même effet, voir *infra*, annexe A, pp. 190-192, note 76 et le Tableau IV. L'Ontario (CRDO, *op. cit.*, note 2, p. 233) a cependant opté pour une réglementation du phénomène. L'ASSOCIATION DU BARREAU CANADIEN (*op. cit.*, note 281, p. 29) en vient aux conclusions suivantes :

> [TRADUCTION]
> Pour ce qui est du mode de réglementation, le Comité a envisagé la position recommandée par la Commission de réforme du droit de l'Ontario et portant établissement d'un mécanisme de sélection et d'autorisation judiciaire préalable, par opposition au mécanisme traditionnel de révision a posteriori. Le Comité a conclu que ce système serait trop lourd et risquerait de ne pas être suivi, même s'il était réglé par un texte législatif. On se trouverait à établir un système différent pour une forme particulière de procréation assistée, chose qui devrait être évitée à moins d'une raison majeure. Le fait que ces ententes visent délibérément la conception d'un enfant en vue de sa remise à une autre personne n'est pas une raison suffisante pour justifier l'élaboration d'un régime distinct. Le Comité a constaté que la plupart des pays qui ont légiféré sur ce sujet ont conservé la procédure traditionnelle de révision a posteriori.
>
> Dans la mesure du possible, la maternité de substitution devrait être assimilée au modèle actuel de l'adoption.

En conséquence, l'Association du Barreau canadien recommande (*id.*, p. 30) [TRADUCTION] « de ne pas encourager la maternité de substitution, mais d'en favoriser l'exécution dans les rares cas où la femme porteuse accepte de remettre l'enfant et où elle a pu bénéficier de toute la protection possible. »

646. Voir *supra*, les rubriques « La légalité et la légitimité », p. 73, et « La force exécutoire du contrat de maternité de substitution », p. 93.

647. Voir Rapport Warnock, *op. cit.*, note 425, p. 73.

648. C'est d'ailleurs le parti adopté par la plupart des pays. Voir *infra*, annexe A, pp. 190-192 et le tableau IV. R. Alta CHARO, « Surrogate Parenting: Analysis and Recommendations for Public Policy » (1989), 10:1 *J. Leg. Med.* 251, 255 : [TRADUCTION] « Le rapport de l'OTA montre, documents à l'appui, que la maternité de substitution à titre onéreux a été dénoncée dans tous les rapports gouvernementaux du monde entier à l'exception de celui de la Commission de réforme du droit de l'Ontario. » Depuis, le National Bioethics Consultative Committee, en Australie, a publié, en avril 1990, son premier rapport sur le sujet de la maternité de substitution. THE NATIONAL BIOETHICS CONSULTATIVE COMMITTEE, *Surrogacy: Report 1*, Adelaïde, le Comité, 1990, p. 36.

> [TRADUCTION]
> 6.4 En conséquence, le Comité recommande ce qui suit :
>
> *a*) La maternité de substitution ne devrait pas être entièrement prohibée.
>
> *b*) La maternité de substitution ne devrait pas être permise sans restriction.
>
> *c*) La maternité de substitution devrait être rigoureusement réglementée par une législation uniforme.
>
> *d*) La législation uniforme devrait prévoir notamment :
> (i) que les contrats de maternité de substitution sont inexécutoires ;
> (ii) des mécanismes de contrôle à l'égard des organismes ;
> (iii) la limitation de la publicité.

Voir aussi THE NATIONAL BIOETHICS CONSULTATIVE COMMITTEE, *Discussion Paper on Surrogacy 2 — Implementation*, Adelaïde, le Comité, 1990.

Les libertés individuelles ont d'ailleurs souvent fait l'objet de restrictions en pareilles circonstances[649]. Les interdictions en matière d'adoption en sont des exemples. Les lois sur l'adoption et sur la protection de l'enfant prohibent en effet de façon expresse la vente d'enfant[650]. Toutefois, même si ces dispositions étaient applicables aux enfants nés de femmes porteuses, rappelons qu'à l'extérieur du contexte de l'adoption, un tel commerce risque d'échapper aux dispositions existantes[651]. En effet, puisque ces dispositions ne s'appliquent que lorsque le but de l'opération est l'adoption de l'enfant[652], si aucune procédure d'adoption n'est engagée en vue d'établir la filiation[653], personne ne peut être traduit en justice. De plus, même lorsqu'il y a adoption, si l'opération à titre onéreux qui l'a précédée n'est pas portée à l'attention du tribunal, elle restera impunie.

L'interdiction de la vente d'êtres humains est une valeur fondamentale qui fait l'objet d'un consensus et que le législateur doit prendre en considération. C'est à ce dernier qu'il incombe d'intervenir afin d'exprimer sans équivoque la position et les valeurs de la société à un moment donné au sujet d'une question aussi fondamentale.

L'argument selon lequel il ne s'agit pas d'une vente d'enfant mais de la rémunération d'un service est peu convaincant puisque l'opération a pour but la remise de l'enfant. Contrairement à l'adoption, l'enfant est ici conçu dans le but précis d'être remis en échange d'une somme d'argent. Et rappelons que le paiement va très souvent au-delà des frais

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649. Même les tenants de la protection du droit de procréer sont généralement d'avis qu'une telle protection ne s'étend pas à l'aspect commercial. Voir à titre d'exemple, R.A. CHARO, *loc. cit.*, note 313, 108 :

> [TRADUCTION]
> L'interdiction de la commercialité ne vise que le droit de rémunérer la maternité de substitution, et non celui de procréer. Et comme la décision de devenir femme porteuse est souvent motivée, aux dires des femmes qui ont pris cette décision, par des considérations non pécuniaires, comme le désir d'aider autrui, il y a lieu de maintenir l'interdiction de la commercialité. Il s'agit en effet d'une expression raisonnable de l'intérêt de l'État qui ne porte pas une atteinte abusive au droit de procréer. Cette position est d'ailleurs partagée par au moins deux tribunaux de l'État.

Rappelons que dans la décision *Baby M* (précitée, note 305), même si la Cour suprême du New Jersey a donné la garde de l'enfant au père de l'enfant et des droits de visite à la femme porteuse, la Cour a également décidé :

> [TRADUCTION]
> Nous tenons le contrat de maternité de substitution pour invalide parce qu'il contrevient au droit et aux objectifs publics de l'État. Nous comprenons la grande détresse des couples infertiles qui ne pourront mettre au monde leurs propres enfants, mais le versement d'une rémunération à une « femme porteuse » nous paraît illégal, voire criminel, et éventuellement dégradant pour la femme [p. 1234]. [. . .] Il s'agit ici de la vente d'un enfant ou, à tout le moins, de la vente des droits de la mère sur son enfant, la seule circonstance atténuante étant que l'un des acheteurs est aussi le père de l'enfant. Les risques d'abus qui ont amené le législateur à interdire les paiements en matière d'adoption sont presque tous présents ici [p. 1248]. [. . .] En somme, les effets néfastes de cette entente de maternité de substitution nous semblent par trop évidents. Au New Jersey, l'engagement de la femme porteuse à vendre son enfant est nul. Son irrévocabilité vicie l'ensemble du contrat, tout comme la contrepartie en argent qui doit servir à acheter l'enfant [p. 1250].

Voir également *Doe* c. *Kelley*, précité, note 313.

650. Voir *supra*, p. 74 et suiv. ainsi que la note 312.

651. Voir *supra*, p. 75.

652. À l'exception du Manitoba, voir *supra*, note 314.

653. Voir le texte sous la rubrique « La filiation juridique », *supra*, p. 76.

engagés. De plus, le rôle joué par les intermédiaires et les honoraires qui leur sont versés mettent en évidence l'aspect commercial de l'opération. Même s'il ne s'agissait pas d'une vente d'enfant, le résultat s'y apparente trop pour être traité différemment. La commercialisation de la maternité de substitution (rémunération de la femme porteuse et des intermédiaires) devrait être expressément prohibée. Cette recommandation s'inscrit dans la logique des prohibitions qui existent en matière d'adoption et de protection de l'enfance[654]. Compte tenu de la nature de la prohibition en cause et de la nécessité d'une intervention uniforme, la Commission considère que le *Code criminel* pourrait être l'outil adéquat[655].

Cela dit, si l'aspect commercial de la maternité de substitution doit faire l'objet d'une prohibition, ce serait, de l'avis de la Commission, faire preuve d'une très grande sévérité que de jeter l'opprobre de la criminalité sur le couple infertile, déjà aux prises avec l'angoisse de l'infécondité, et à la femme porteuse qui leur vient en aide. Et il y a gros à parier que les couples, qui ne cherchent en somme qu'à réaliser un désir légitime, ne s'en trouveront pas dissuadés pour autant. La prohibition pénale risquerait de repousser le phénomène dans la clandestinité totale, avec les risques que cela comporte[656]. En effet, la clandestinité engendre l'irresponsabilité en rendant presque impossible, par peur des représailles, le recours aux tribunaux. L'enfant pourrait alors être exposé à des risques tant physiologiques que psychologiques. L'application sans discernement d'une prohibition pénale aux premiers intéressés (la femme porteuse, son conjoint et les parents sociaux) risque donc de faire plus de tort que de bien. Même si leur conduite est répréhensible, nous ne sommes pas convaincus qu'il convienne de leur infliger des sanctions criminelles. Une prohibition aveugle ne saurait en réalité apporter une contribution suffisante à la résolution du problème, ni se justifier au regard des principes du droit pénal[657]. En tout état de cause, elle n'est certainement pas dans l'intérêt de l'enfant : à qui, en effet, en confiera-t-on la garde une fois que ses parents auront été poursuivis, reconnus coupables et éventuellement emprisonnés ?

Afin d'atteindre plus efficacement le but poursuivi (éviter que ne se crée un trafic d'enfants et décourager quiconque à cet égard), la Commission est d'avis qu'il y a lieu d'insérer au *Code criminel* une prohibition visant l'activité des intermédiaires rémunérés. Puisque ce sont ces intermédiaires qui favorisent l'émergence d'un trafic d'enfants, le fait de décourager ce genre d'activité contribuerait grandement à éviter la commercialisation de la maternité de substitution. D'autre part, en soustrayant les premiers intéressés à

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654. Voir *supra*, les rubriques « La commercialité », p. 74 et « La force exécutoire du contrat de maternité », p. 93. Rappelons toutefois que, sous certaines conditions, l'Ontario et la Colombie-Britannique permettent certains paiements en matière d'adoption. En Colombie-Britannique, par exemple, un paiement serait possible s'il est autorisé par la cour ; voir *Adoption Act*, précité, note 312, art. 15.1. Pour l'Ontario, voir *Loi de 1984 sur les services à l'enfance et à la famille*, précitée, note 312.

655. *Notre droit pénal*, *op. cit.*, note 584. Rappelons que la portée des dispositions existantes du *Code criminel* est insuffisante ; voir *supra*, p. 76.

656. Sur les obstacles à l'efficacité d'une intervention du législateur, voir R.L. KIDDER, *op. cit.*, note 9, p. 112 et suiv., à la p. 117 : [TRADUCTION] « [L]es modifications soudaines du droit n'ont pas toujours l'effet souhaité par les tribunaux ou le législateur [...] Il arrive qu'un texte de loi adopté dans un but précis ait des effets secondaires imprévus ou que le résultat soit diamétralement opposé au but visé. » Concernant la modification de l'effet d'une loi par ceux qui y sont visés, voir plus particulièrement *id.*, pp. 136-137.

657. Voir *Notre droit pénal*, *op. cit.*, note 584, p. 34.

l'application de la prohibition, on se trouvera à encourager la dénonciation des intermédiaires. Dans ces conditions, l'effet de dissuasion devrait être important, puisque les intermédiaires auront trop à risquer, la loi du silence ne leur étant alors d'aucun secours. En effet, en s'engageant dans cette activité, l'intermédiaire s'exposera à être découvert, puis poursuivi, dans de nombreuses situations : par exemple, si la femme porteuse se comporte de façon fautive pendant la grossesse, si elle refuse de remettre l'enfant à la naissance, si les parents sociaux refusent l'enfant, etc.

C'est un objectif louable que de vouloir empêcher la mercantilisation de la maternité de substitution et, pour ce faire, une intervention législative est nécessaire. Mais l'on doit cependant tenir compte de l'effet réel d'une telle intervention et d'autres facteurs tout aussi importants tels que la sécurité de l'enfant. L'interdiction absolue de la maternité de substitution pourrait donner la fausse impression que le problème est résolu. Nous croyons qu'il est plus réaliste et efficace de réprimer seulement l'activité des intermédiaires rémunérés que de tenter de prévenir la conclusion de toute entente entre particuliers à ce sujet. Ce faisant, le Canada se trouverait à emboîter le pas à la grande majorité des pays qui ont pris position sur la question[658].

RECOMMANDATION

4. Le contrat de maternité de substitution doit demeurer nul de nullité absolue. De plus, le fait d'agir comme intermédiaire rémunéré dans la conclusion d'un tel contrat devrait constituer une infraction criminelle.

La recommandation qui précède n'a toutefois pas fait l'unanimité chez les commissaires. Suivant la position minoritaire, il est à la fois inutile et malavisé d'incriminer seulement la rémunération d'un intermédiaire dans le cadre d'un contrat de maternité de substitution. Aussi, l'une ou l'autre des solutions de rechange proposées leur paraît-elle encore préférable à la position adoptée par la majorité.

Le but de la prohibition pénale envisagée est de réprimer le commerce de l'être humain. Pour la majorité des commissaires, en effet, la maternité de substitution à titre onéreux revient à une forme de trafic d'enfants et devrait être interdite. Pourtant, la situation n'est pas vraiment différente de celle où des gens se livrent au commerce d'enfants déjà nés. Et les angoisses de l'infertilité et de la grossesse n'atténuent en rien le caractère répréhensible

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658. R.A. CHARO, *loc. cit.*, note 313, 108 ; voir à titre d'exemple, le *Surrogacy Arrangements Act 1985* (précité, note 425), qui interdit la maternité de substitution à titre onéreux, et criminalise l'activité des agences spécialisées ou autres intermédiaires. La loi n'interdit pas de façon absolue les paiements à la femme porteuse. Le Rapport Warnock, *op. cit.*, note 425, pp. 75-77, prévoit des sanctions contre les intermédiaires et professionnels qui opèrent soit à titre onéreux, soit à titre gratuit. Le White Paper du Royaume-Uni énonce cependant une opinion contraire, DEPARTMENT OF HEALTH AND SOCIAL SECURITY, *Human Fertilisation and Embryology: A Framework for Legislation*, Londres, HMSO, 1987, par. 73, p. 12 : [TRADUCTION] « Néanmoins, le gouvernement ne croit pas qu'il soit opportun, ni nécessairement dans l'intérêt véritable de l'enfant, d'incriminer la maternité de substitution — si ce n'est l'activité d'organismes à but lucratif. Le projet de loi n'ajoutera pas aux sanctions prévues par la loi de 1985. » Pour plus de détails, voir *infra*, annexe A, pp. 190-192 ainsi que le tableau IV.

de l'opération. Certes, ces circonstances peuvent justifier que l'on fasse preuve de clémence au moment de la détermination de la peine ; elles ne sauraient en revanche servir à soustraire les parents sociaux et la femme porteuse à la responsabilité pénale. Si l'on doit considérer cette pratique comme suffisamment condamnable pour justifier la sanction du droit pénal, en toute logique, aucune des parties à l'entente ne devrait y échapper.

Quoi qu'il en soit, toujours selon la minorité, le refus de reconnaître la moindre force exécutoire au contrat ferait beaucoup plus pour enrayer la maternité de substitution qu'une prohibition pénale. Le contrat devrait dans tous les cas être tenu pour contraire à l'ordre public et, partant, pour nul et non avenu. Cette solution emporte deux conséquences. En premier lieu, l'enfant conçu en application du contrat serait présumé être l'enfant naturel de la femme qui l'a porté. Les parents sociaux n'auraient donc aucun recours pour forcer celle-ci à leur remettre l'enfant. En second lieu, l'intermédiaire ne pourrait réclamer de rétribution pour les services qu'il a fournis ; il pourrait éventuellement être contraint de remettre la rémunération qui lui aurait été versée. Devant une situation juridique aussi aléatoire, on peut penser que la plupart des gens hésiteront à s'engager dans une entente semblable, surtout lorsqu'un paiement est en jeu. Un tel régime, étayé d'infractions de nature réglementaire comportant des amendes sévères ou d'autres types de peine, réussirait sans doute à dissuader qui que ce soit de recourir à la maternité de substitution à titre onéreux.

D. L'autorité sur les gamètes et les embryons

La question des droits pouvant s'exercer sur les produits génétiques et de leurs limites pose des problèmes tant sur le plan de l'application des lois et des principes du droit existant que sur celui du respect des valeurs et principes fondamentaux de notre société, notamment les libertés individuelles et la dignité humaine[659].

Les remarques qui suivent devraient être lues à la lumière du fait que les techniques de procréation médicalement assistée ne sont pas encore assez avancées pour éviter la création d'embryons surnuméraires. À long terme, on ne peut que souhaiter la disparition de ce problème. Pour le moment, il nous semble peu réaliste de refuser, au nom de principes moraux ou éthiques, de tenir compte de cette réalité[660].

L'incertitude quant au sort des gamètes et embryons congelés lorsque, par exemple, un couple divorce ou lorsqu'un conflit survient (que ce soit entre les conjoints ou entre la banque et ses clients), et quant à la nature de l'autorité qu'exerce le géniteur sur ses gamètes et les embryons qui en sont issus est source de conflits juridiques pour lesquels le droit actuel n'a pas de solution. Qui peut en disposer, en vertu de quoi et dans quelles limites ? Existe-t-il des limites à l'utilisation qui peut en être faite ? La jurisprudence récente[661] nous enseigne que les tribunaux sont très embarrassés lorsqu'il s'agit de statuer sur le sort des gamètes et des embryons congelés dans ces circonstances. Et les décisions rendues témoignent également des difficultés et des risques qui surgissent lorsque la

659. Voir Conseil de l'Europe, *op. cit.*, note 610, p. 11.

660. Voir à ce sujet, *supra*, pp. 132-133.

661. Voir *supra*, notes 206-208.

résolution de tels conflits est abandonnée entièrement au système judiciaire. Dans l'affaire *Parpalaix*[662], par exemple, la question centrale, soit l'utilisation posthume des gamètes, a été éludée. Par ailleurs, la décision du juge de première instance dans l'affaire américaine *Davis*[663] illustre les dangers de l'absolutisme lorsqu'il s'agit du statut de l'embryon. Enfin, la nécessité pour un couple de s'adresser aux tribunaux afin de pouvoir disposer de leurs embryons aux fins de procréation est difficile à accepter[664]. La question de l'autorité sur les gamètes et les embryons soulève donc des difficultés qui réclament une solution. Quel doit être le régime juridique applicable ?

1. L'embryon

La nature de l'embryon rend difficile la qualification de son statut (bien ou personne) ainsi que la détermination de son appartenance au domaine privé du droit des biens ou au domaine public du droit des personnes (dont on ne peut disposer)[665]. Devant cette impasse, comment résoudre le problème de l'autorité sur l'embryon ?

Différentes solutions s'offrent au législateur : créer une catégorie pour l'embryon qui pourrait se situer entre les choses et les personnes, adopter des règles de droit qui emprunteraient de ces deux catégories[666], confier cette question à l'application des règles du droit des biens[667], prévoir à l'avance la solution des conflits éventuels (don à des tiers, destruction ou expérimentation) au moyen de la réglementation des banques[668] ou, enfin,

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662. Précitée, note 206.

663. Précitée, note 207, 2. Rappelons cet extrait des motifs du juge W. Dale Young : [TRADUCTION] « (7) La vie humaine commence dès la conception. (8) M. et M^me^ Davis ont conçu in vitro des êtres humains appelés à devenir leurs enfants. » Pour une critique de cette decision, voir E. SHUSTER, *loc. cit.*, note 627, 976 et suiv.

664. *York* c. *Jones Institute*, précité, note 208. Voir *supra*, note 221.

665. Voir B. KEATING, *op. cit.*, note 620.

666. Catherine LABRUSSE-RIOU, « Réflexions terminales », dans Raphaël DRAÏ et Michèle HARICHAUX (dir.), *Bioéthique et droit*, Paris, P.U.F., 1988, p. 269, à la page 275 : « Il importe que le droit positif préserve ses catégories de "personne" opposée à "chose", ou la notion d'identité civile définie par la catégorie "état de la personne" dont on ne dispose pas ; mais à l'intérieur de ces catégories, il faudrait être imaginatif pour trouver des règles qui, elles, peuvent évoluer, pour régir ces situations nouvelles auxquelles nous sommes confrontés. » La Louisiane reconnaît à l'ovule fécondé le statut de « personne juridique » jusqu'à ce qu'il soit implanté dans l'utérus. En tant que « personne juridique », l'ovule fécondé ne peut donc être considéré comme un bien et pourrait intenter une poursuite ou être poursuivi. Les donneurs de gamètes sont considérés comme ses parents ; à défaut, la clinique médicale est désignée tutrice de l'embryon. De cette qualification découle l'interdiction de détruire un embryon in vitro qui a le potentiel de se développer normalement. Bien qu'il ait la « personnalité juridique » avant son implantation, l'embryon n'acquiert de droits successoraux qu'à sa naissance et ceux-ci seront reliés aux parents « naturels » ou adoptifs (voir *infra*, annexe A, p. 192). En France, le Comité national d'éthique a caractérisé l'embryon humain par le qualificatif de « personne potentielle », relevant donc du droit des personnes et non des biens. Voir à ce sujet C. LABRUSSE-RIOU, *id.*, p. 273 ; B.M. KNOPPERS, *loc. cit*, note 225, 343 et suiv. L'auteure souligne que des recommandations provenant de commissions de réforme du droit (américaines, européennes et du Commonwealth) se dégage un consensus sur le besoin de protéger le matériel génétique sans nécessairement lui accorder la personnalité juridique.

667. La volonté des « propriétaires » serait déterminante. Les ententes ainsi signées devraient être respectées par la législation sur le divorce et le droit des successions. Il serait également possible de faire du contrat de dépôt un contrat d'adhésion.

668. Voir CONSEIL D'ÉTAT, *Avant-Projet de Loi sur les sciences de la vie et les droits de l'Homme*, 1989, art. 10, p. 58 [non publié] ; voir aussi *infra*, annexe A, p. 193. En cas de mort, divorce ou séparation, les gamètes seraient détruits.

s'abstenir d'intervenir sur le fond tout en s'assurant que, au moment de donner leur consentement, les titulaires de l'autorité ont prévu le sort des embryons dans le cas où se réaliseraient certaines situations précises[669].

S'il va de soi que laisser la détermination du sort de l'embryon au droit des biens est tout à fait contraire à l'éthique[670], il paraît à tout le moins prématuré de suggérer au législateur de créer une nouvelle catégorie juridique pour ces sources de vie potentielles. Il lui incombe toutefois d'élaborer des règles juridiques particulières qui, tout en permettant aux débats éthiques de se poursuivre[671], assureront la protection de l'embryon. Ces règles juridiques pourraient s'articuler autour du consentement écrit et signé par les géniteurs avant la conception[672].

Le consentement donné par écrit avant la conception permet au titulaire de l'autorité sur les embryons qui seront conçus d'exprimer sa volonté à l'égard de ceux-ci et de leur conception. Il est par ailleurs important que les choix posés puissent, avant l'utilisation des embryons aux fins prévues, être modifiés[673]. Il est aussi évident que, lorsque l'autorité est partagée par un couple, toute modification devrait faire l'objet d'un commun accord.

RECOMMANDATION

5. (1) Avant la conception d'un embryon en vue d'un usage personnel futur, le ou les titulaires éventuels de l'autorité sur l'embryon devraient être tenus d'exprimer par écrit leur volonté quant au sort de l'embryon dans les cas suivants, notamment : décès du titulaire de l'autorité, abandon du projet parental, expiration du délai de congélation, divorce ou conflit entre les titulaires de l'autorité. Le titulaire de l'autorité sur un embryon devrait pouvoir, par écrit, modifier l'expression de sa volonté quant au sort de l'embryon tant que celui-ci n'a pas été utilisé aux fins prévues ; dans le cas où l'autorité serait partagée, toute modification devrait se faire d'un commun accord.

Mais à qui revient l'autorité sur l'embryon ? En principe, elle devrait être fonction à la fois de la contribution génétique et de l'intention des parties, mais que faire lorsque ces deux éléments entrent en conflit ?

Lorsque l'embryon est le produit génétique du couple, les deux partenaires ont des droits égaux qui sont supérieurs à ceux que pourrait avoir la banque ou la clinique qui a la possession de l'embryon. Ainsi, les embryons issus des gamètes du couple devraient

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669. Le choix possible quant au sort des embryons sera évidemment limité par l'utilisation que peuvent en faire les titulaires de l'autorité sur ceux-ci (expiration du délai de congélation, divorce, etc.) ; voir *infra*, rec. 5(3).

670. Suivant une recommandation antérieure de la CRD (*L'expérimentation biomédicale sur l'être humain*, *op. cit.*, note 7, p. 54), le droit ne doit jamais traiter l'embryon ni le fœtus comme de simples objets.

671. Sur toute cette importante question du statut de l'embryon, voir B. KEATING, *op. cit.*, note 620.

672. Voir E. SHUSTER, *loc. cit.*, note 627, 977. Voir également John A. ROBERTSON, « Prior Agreements for Disposition of Frozen Embryos » (1990), 51 *Ohio St. L.J.* 407.

673. Voir *supra*, pp. 57-58.

être sous l'autorité conjointe des partenaires qui auraient le pouvoir exclusif de déterminer le sort des embryons surnuméraires et des embryons congelés. L'implantation éventuelle serait donc conditionnée par l'assentiment du couple. Par conséquent, la clinique et la banque n'auraient aucun droit de retenir les embryons, ni de contrevenir de quelque façon à la volonté du couple. Elles n'auraient que les droits qui leur auraient été expressément délégués.

Dans l'hypothèse où l'embryon est en partie le produit du don d'un tiers, il est évident que le donneur ne peut prétendre à des droits sur l'embryon[674]. On peut en revanche s'interroger sur la situation du conjoint qui n'a aucun lien génétique avec l'embryon. Si la volonté de chaque partie doit être considérée, le lien génétique vient toutefois investir le conjoint dont on a utilisé les gamètes d'un intérêt supérieur à celui de l'autre conjoint. En cas de conflit quant au sort de l'embryon, la volonté du conjoint géniteur doit prévaloir.

Dans le cas où l'embryon a été conçu grâce à deux gamètes donnés (c'est-à-dire lorsque l'embryon n'est génétiquement lié à aucun des futurs parents), l'autorité sur cet embryon serait dévolue à la banque ou la clinique qui en a la possession.

RECOMMANDATION

5. (2) L'autorité sur l'embryon issu des gamètes d'un couple devrait être exercée conjointement par les partenaires. L'autorité sur l'embryon issu des gamètes d'un seul des partenaires d'un couple et d'un donneur devrait être exercée exclusivement par le conjoint lié génétiquement à l'embryon. L'autorité sur l'embryon issu des gamètes de deux donneurs devrait être exercée par la banque ou la clinique qui en a la possession.

Quelles sont les limites de l'autorité qui peut s'exercer sur l'embryon ? Quels sont les choix que peuvent faire les titulaires de cette autorité quant au sort de l'embryon ? Existe-t-il un intérêt supérieur justifiant la limitation des décisions que peut prendre un couple quant à la façon de disposer de l'embryon ? La Commission s'est déjà prononcée sur la meilleure façon de disposer des embryons surnuméraires : à leur destruction pure et simple, elle préfère le don aux fins d'implantation et, à défaut, d'expérimentation. Aucune solution n'est parfaite : à ceux qui s'opposent au don au nom d'un projet parental, on peut rétorquer que la destruction peut être tout aussi inacceptable. Mais que faire alors ?

Il convient ici de réitérer la position que nous avons déjà prise : le titulaire de l'autorité peut soit donner ses embryons aux fins d'implantation, soit permettre à la science de les utiliser à l'intérieur des limites déjà énoncées, soit réclamer leur destruction[675]. Cela

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674. Nous reviendrons plus loin sur les droits du donneur sur ses gamètes.

675. *L'expérimentation biomédicale sur l'être humain*, *op. cit.*, note 7, p. 57. J.A. ROBERTSON, *loc. cit.*, note 220, 10 : [TRADUCTION] « Il se dégage des travaux du Ethics Advisory Board, du Comité Warnock, de l'American Fertility Society et de la plupart des commissions d'éthique qui ont étudié la question dans le monde entier, un consensus suivant lequel il est possible de faire preuve d'un respect particulier pour l'embryon sans pour autant le traiter comme une personne ni interdire au couple de s'opposer à son transfert. » Voir également J.A. ROBERTSON, *id.*, 10, n. 15.

revient à dire que les choix des titulaires de l'autorité sur l'embryon quant à l'utilisation de celui-ci se limitent à l'implantation, à l'expérimentation et à la destruction[676].

RECOMMANDATION

5. (3) L'utilisation de l'embryon devrait être limitée à l'implantation, à l'expérimentation et à la destruction ; à l'échéance du délai de congélation, toutefois, l'implantation devrait être prohibée.

Dans le cas où le titulaire de l'autorité sur un embryon déciderait d'en faire don, il devrait exprimer par écrit les conditions auxquelles il souhaite assortir le don, c'est-à-dire les conditions liées à l'utilisation qui pourra être faite de l'embryon[677]. Il est également important qu'il puisse modifier ces conditions ou encore retirer son consentement en tout temps avant l'utilisation de l'embryon[678].

RECOMMANDATION

5. (4) Le titulaire de l'autorité sur un embryon qui décide de donner celui-ci devrait être tenu, avant l'exécution du don, de faire une déclaration écrite exprimant son consentement au don et énumérant les conditions auxquelles celui-ci est assujetti quant à l'utilisation de l'embryon. Il devrait aussi pouvoir, au moyen d'une déclaration écrite, modifier ces conditions ou retirer son consentement en tout temps avant l'utilisation de l'embryon donné ; dans le cas où l'autorité serait partagée, toute modification devrait se faire d'un commun accord.

2. Les gamètes

Devons-nous traiter les gamètes différemment d'un simple bien matériel ? Cette question doit être abordée dans le cadre d'une réflexion plus générale sur le régime juridique à appliquer au corps humain, à ses parties et à ses substances[679]. La finalité procréative du matériel génétique rend encore plus évidente la nécessité d'une telle interrogation. S'il

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676. Voir également à ce sujet E. SHUSTER, *loc. cit.*, note 627, 977.

677. Voir *supra*, p. 57.

678. Voir *supra*, pp. 57-58. Les conditions possibles seront limitées en fonction de l'utilisation permise de l'embryon par les titulaires de l'autorité ; voir rec. 5(3).

679. M.-A. HERMITTE, *loc. cit.*, note 211, 325. Entre la personne et la chose, Hermitte suggère que le corps humain, ses parties et substances, s'inscrivent dans la catégorie de la « chose d'origine humaine et à finalité humaine ». J.-C. GALLOUX, *loc. cit.*, note 623, 3-4, 31, par contre, exclut la possibilité de créer une catégorie autre que celle des choses et des personnes :

> La division du monde juridique en deux séries distinctes, les choses et les personnes, relève de l'expérience première ; sans elle le droit ne pourrait se concevoir. Cette « Summa divisio » du droit emporte deux corollaires : les catégories de la réalité juridique sont spécifiques et

va de soi que les gamètes ne peuvent être considérés comme des personnes, les qualifier de choses revient à faire abstraction de leur nature.

Comme nous l'avons vu[680], la spécificité biologique du spermatozoïde et de l'ovocyte a amené la Commission à conclure que les gamètes et les embryons ne peuvent être considérés ni comme de simples cellules, ni comme de simples tissus[681]. Sources virtuelles de nouvelles vies humaines, les gamètes doivent bénéficier d'un traitement qui s'apparente à celui qui est accordé à l'embryon.

L'autorité sur les gamètes pourrait appartenir au domaine privé, sans toutefois qu'on applique le régime juridique réservé aux choses, et s'exercer par l'expression de la volonté du géniteur. L'expression écrite de cette volonté permettrait à la personne qui dépose ses gamètes en vue de son propre usage d'affirmer ses droits et de prévoir les mesures à prendre lorsque, par exemple, elle renonce à utiliser les gamètes qu'elle a déposés ou que le délai de conservation est écoulé. D'autre part, le formulaire de consentement permettrait au donneur d'assujettir à des conditions l'utilisation de ses gamètes, et de retirer son consentement avant l'utilisation.

RECOMMANDATION

6. (1) L'autorité sur les gamètes devrait être attribuée au géniteur.

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exclusives. Elles sont spécifiques dans la mesure où elles dénotent des existants d'essence ou de nature particulière, et elles sont contradictoires : un existant ne peut être à la fois chose et personne et le passage d'une catégorie à l'autre ne se conçoit qu'à moins d'enlever toute permanence à l'essence de ces êtres, ce que le droit n'admet pas. Elles sont exclusives en ce sens que le droit n'offre aucune place à une catégorie tierce : ce n'est là que l'application traditionnelle du principe du tiers exclu que notre système juridique reprend. [...]

Le matériel génétique, quelle que soit son origine animale, végétale ou humaine, et à quelque niveau qu'on l'appréhende, matériel ou informationnel, est une chose. Cette solution rend l'analyse des problèmes juridiques posés par la génétique cohérente au savoir scientifique, et cohérente à notre système de droit fondé sur des catégories spécifiques. Elle confirme la nature fondamentalement métabiologique et non conventionnelle de la personne. Attribuer une nature personnelle au matériel génétique humain revient à rompre l'unité fondamentale du vivant, et à donner de la personne et des choses une définition circonstancielle dont l'incorporation serait le critère. Cette démarche peu rationnelle ouvre à un danger d'arbitraire dans le droit. Elle livre enfin la personne à un réductionnisme biologique, conséquence inévitable de la négation de sa dimension métaphysique.

La qualification réelle n'implique aucune dévalorisation du vivant. Elle n'implique pas plus son appropriation ou son commerce : les catégories fondamentales de la chose commune et des choses hors du commerce nous le rappellent. Elle ne nie pas la valeur du matériel génétique et du corps humain. Elle consacre plutôt l'idée que la valeur s'apprécie non dans la nature de la chose, mais en relation avec l'intimité et la nécessité du lien qui unit la chose à la personne. C'est donc au stade du régime juridique de ces « choses génétiques » que le droit devra promouvoir la défense du vivant et la protection de la dignité de l'homme.

Galloux utilise toutefois les notions d'extra-commercialité et d'affectation afin de limiter le commerce juridique (actes juridiques ayant pour but de créer, modifier ou éteindre des droits) des produits du corps. Voir à ce sujet, J.-C. GALLOUX, *loc. cit.*, note 212.

680. Voir *supra*, p. 133.

681. *L'expérimentation biomédicale sur l'être humain*, *op. cit.*, note 7, p. 59.

(2) La personne qui dépose ses gamètes en vue d'un usage personnel futur devrait être tenue, avant le dépôt, d'exprimer par écrit sa volonté quant au sort des gamètes dans les cas suivants, notamment : décès du titulaire de l'autorité, abandon du projet parental et expiration du délai de congélation. Le déposant devrait pouvoir, au moyen d'une déclaration écrite, modifier l'expression de sa volonté quant au sort de ses gamètes avant la conception d'embryons ou l'utilisation à laquelle les gamètes étaient destinés.

Dans le cas où le géniteur ferait don de ses gamètes, il devrait exprimer par écrit les conditions auxquelles il souhaite assujettir le don, quant à l'utilisation qui pourra être faite des gamètes[682]. Il est également important qu'il puisse modifier ces conditions ou encore retirer son consentement[683].

RECOMMANDATION

6. (3) La personne qui fait don de ses gamètes devrait être tenue avant l'exécution du don, de faire une déclaration écrite exprimant son consentement au don et énumérant les conditions auxquelles celui-ci est assujetti quant à l'utilisation des gamètes. Le donneur devrait pouvoir, par écrit, modifier ces conditions ou retirer son consentement en tout temps avant la conception d'embryons ou l'utilisation des gamètes donnés.

(4) L'utilisation des gamètes devrait être limitée à la fécondation, à l'expérimentation et à la destruction ; à l'échéance du délai de congélation, toutefois, la fécondation devrait être prohibée.

3. L'utilisation posthume des gamètes et des embryons

Devons-nous restreindre l'utilisation des gamètes et des embryons après la mort de leurs géniteurs ou de l'un des partenaires ? Devons-nous interdire leur utilisation par le survivant ? La définition de la famille devrait-elle s'étendre à la procréation posthume ? Nous retrouvons ici toute la question de la limitation des libertés individuelles et de la force des contrats.

La réponse à ces questions peut dépendre de la politique adoptée en matière d'accès à la procréation médicalement assistée. Opter pour la protection de la famille biparentale reviendrait à imposer une limite au consensualisme. Cependant, à défaut d'adopter une politique visant la protection de la famille biparentale, devons-nous nécessairement permettre la remise au conjoint survivant ? Certains prétendront que les problèmes psychologiques qui peuvent en résulter, tant pour le conjoint survivant que pour l'enfant à naître, sèment le doute quant à l'opportunité de respecter à ce point la liberté consensuelle

682. Voir *supra*, p. 57. Les choix possibles quant au sort des gamètes seront évidemment limités à l'utilisation que peut en faire le titulaire de l'autorité ; voir rec. 6(4). Concernant le délai de congélation, voir rec. 12(2).

683. Voir *supra*, pp. 57-58.

et devraient nous inciter à la prudence. Pour cette raison et compte tenu de la nature même du projet parental, les choix s'offrant à l'exercice de l'autorité sur les gamètes et les embryons en cas de décès d'un géniteur devraient être limités comme suit : don aveugle, expérimentation ou destruction[684].

Cela dit, d'autres pourront arguer de la nouveauté du phénomène pour soutenir qu'il est difficile de motiver adéquatement une restriction à la liberté à cet égard. Pour sa part, la Commission est d'avis qu'il n'y a pas lieu d'interdire la remise des gamètes ou des embryons au partenaire survivant à la mort d'un géniteur. Des dispositions en matière de filiation et de successions devront donc être prévues à cet effet[685].

Le lecteur aura compris que les solutions proposées dans nos recommandations sur l'autorité s'exerçant sur les gamètes et les embryons font appel à l'exercice des compétences provinciales. Si la Commission a tenu à faire connaître sa position, c'est qu'il lui paraît essentiel d'uniformiser les règles de droit qui devront aider à la résolution des conflits.

E. La filiation

1. Le don de gamètes et d'embryon

La filiation de l'enfant conçu grâce à la procréatique soulève la question de l'application éventuelle, par nos tribunaux, des règles et des principes du droit actuel. Nous avons vu que, face à certaines situations nouvelles rendues possibles par la procréation médicalement assistée, les règles actuelles de la filiation juridique sont insuffisantes et leurs applications, imprévisibles en cas de conflit[686].

Parmi les principaux problèmes soulevés en matière de don de gamètes et d'embryon, nous avons souligné : l'attribution des responsabilités découlant de la paternité à un donneur qui n'a aucunement l'intention d'être père ; le désaveu d'un enfant dont on a voulu la conception ; la possibilité d'une contestation de paternité par un tiers ou le géniteur, et

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684. Par exemple, le CONSEIL DE L'EUROPE (*op. cit.*, note 610, p. 39) ne permet pas l'utilisation posthume des gamètes, eu égard au bien-être de l'enfant et risque de dissociation de l'unité familiale. Le BARREAU DU QUÉBEC (*loc. cit.*, note 3, 24 et suiv.) recommande également de la prohiber car elle aurait pour effet de mettre délibérément au monde un orphelin et risque de créer des dommages psychologiques graves au moment où la situation est révélée. La France l'interdit au nom de la biparentalité. Voir *infra*, annexe A, p. 197 et plus particulièrement la note 135.

685. En Angleterre, par exemple, l'utilisation posthume des gamètes par le conjoint survivant n'est ni interdite ni encouragée. Les partenaires devront, au moment de consentir à la conservation de leurs gamètes ou embryons, prévoir leur disposition en cas de décès. À défaut de mention particulière à cet effet, l'embryon ne sera pas conservé. Avant l'implantation, le partenaire survivant devra recevoir des services de consultation. L'Australie a choisi de ne pas réglementer ni d'interdire l'utilisation posthume. L'Espagne la permet si l'insémination a lieu dans les six mois du décès. L'enfant ne sera reconnu comme descendant du père que si ce dernier l'a reconnu dans son testament ou tout autre acte notarié ; autrement, il n'y aura pas de lien juridique avec le défunt. Pour la position des autres pays et pour plus de détails, voir *infra*, annexe A, p. 197 Concernant les dispositions relatives à la filiation et au droit des successions, voir les pages qui suivent.

686. Voir *supra*, p. 64 et suiv.

d'une réclamation de paternité de la part de ce dernier ; le statut juridique de l'enfant ; la dissociation de la maternité gestatrice et de la maternité génétique[687]. Ces problèmes nous amènent à nous interroger sur l'importance relative à attacher à l'expression de la volonté des futurs parents, ainsi qu'aux critères biologique et social de la paternité et de la maternité. Or, étant donné la diversité des règles de la filiation au Canada[688], la réponse à cette interrogation n'est pas toujours claire, même en matière de procréation naturelle. Cette situation rend d'autant plus évidente la complexité du problème et de sa résolution en matière de procréation médicalement assistée. Malgré ces difficultés, la Commission estime que certaines questions ne peuvent plus être éludées. Ainsi, dans le cas du don de gamètes ou d'embryon, la filiation devrait refléter la volonté des parties au moment du don, soit celle du donneur de n'avoir aucun lien juridique avec l'enfant[689], et celle du couple ou de la receveuse d'en assumer la responsabilité[690].

Le droit de la filiation devrait donc prévoir 1) dans quelles circonstances la présomption de paternité peut être combattue, 2) qu'aucun lien de filiation ne peut être établi entre le donneur et l'enfant, 3) que l'enfant né grâce à la procréatique a le statut d'enfant légitime[691].

RECOMMANDATION

7. (1) Les lois provinciales sur la filiation devraient refléter la volonté des couples qui ont recours à la procréation médicalement assistée et déclarer irrecevables l'action en désaveu de paternité de la part du père qui a consenti au traitement et l'action en contestation de paternité de la part d'un tiers soutenant que l'enfant est issu de gamètes donnés.

(2) Aucun lien de filiation ne devrait pouvoir être établi entre le donneur et l'enfant.

(3) Les législations qui font toujours la distinction entre l'enfant légitime et l'enfant illégitime devraient reconnaître à l'enfant né grâce à la procréation médicalement assistée le statut d'enfant légitime.

Enfin, comme nous avons recommandé de ne pas prohiber la fécondation posthume au moyen des gamètes d'un partenaire décédé, il est essentiel que le droit des successions soit modifié en conséquence. La Commission est d'avis que l'enfant ainsi conçu ne devrait être successible que si une mention expresse à cet effet figure au testament[692].

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687. Nous verrons que ce problème revêt une dimension particulière en matière de maternité de substitution ; voir *infra*, p. 158.

688. Voir *supra*, pp. 64-66.

689. La Conférence sur l'uniformisation des lois au Canada a réaffirmé que le donneur de sperme n'est pas le père de l'enfant né de son don et il n'a aucun droit ou obligation concernant cet enfant : voir la loi modifiant la loi uniforme sur le statut de l'enfant, précitée, note 203, al. 11.4(2).

690. *Id.*, art. 11.2.

691. *Id.*, art. 11.2 et 11.4.

692. Voir dans le même sens, White Paper, *op. cit.*, note 658, par. 60, p. 10. Voir également, de façon générale, *infra*, annexe A, p. 197.

RECOMMANDATION

8. Les lois provinciales sur les successions devraient être harmonisées afin d'établir que l'enfant né grâce à l'utilisation posthume de gamètes ou d'un embryon n'est pas successible à moins d'une mention expresse au testament du géniteur décédé.

2. La maternité de substitution

Même si le contrat de maternité de substitution est fort probablement nul de nullité absolue selon le droit canadien actuel[693], la filiation de l'enfant né à la suite d'une telle entente peut être matière à contestation. La règle attribuant la maternité légale à la femme qui accouche s'applique sans difficulté dans le cas où la femme porteuse est génétiquement liée à l'enfant : elle est à la fois la mère génétique et la mère gestatrice. La mère sociale ne peut lui opposer que son intention d'accéder à la maternité. Si la mère de substitution décide de garder l'enfant, le litige porte essentiellement sur la garde et sera tranché par les tribunaux en fonction de l'intérêt de l'enfant au regard des circonstances de chaque cas.

Le recours à la maternité de substitution pose toutefois une nouvelle question au droit, celle du droit de la mère sociale génétiquement liée à l'enfant de réclamer et de prouver, de la même façon que le père génétique, sa maternité légale[694]. L'application des principes et des règles du droit actuel se retrouve ici au cœur du conflit entre les intérêts de la mère gestatrice, de la mère génétique et de l'enfant. L'intérêt que présente pour ce dernier une filiation claire et un milieu familial stable et aimant ne fait pas de doute. Lorsque la maternité est divisée en dimensions génétique, gestatrice et sociale, il est difficile de trancher en faveur de l'une ou de l'autre. Il est évident que le lien qui s'établit entre la femme porteuse et l'enfant pendant la gestation est important et difficilement comparable avec le lien qui peut s'établir avec le mari de la femme porteuse. Il est donc plus facile pour le père biologique d'opposer son intérêt à celui du mari de la femme porteuse qu'il ne l'est pour la mère génétique de faire de même envers la femme porteuse. Nous ne pouvons pas pour autant écarter l'intérêt de la mère génétique qui joint à son « don » l'intention d'être mère. De plus, la détermination de l'intérêt de l'enfant devient un exercice arbitraire puisque nous n'avons pas les connaissances nécessaires pour choisir entre la femme porteuse et la mère génétique. Un tel choix, fût-il fait au nom de la stabilité de l'enfant, pourrait s'avérer dommageable à long terme.

Nous reconnaissons les lacunes du droit actuel et l'intérêt de la société dans la prévisibilité et la résolution des questions de filiation, ainsi que l'intérêt de l'enfant en la matière. Il nous apparaît toutefois hâtif d'adopter quelque règle que ce soit pour trancher la question de la stabilité en choisissant entre la maternité gestatrice et la maternité

693. Voir *supra*, p. 73 et suiv.

694. Signalons qu'il ne s'agit pas d'un droit découlant du contrat, celui-ci étant nul de nullité absolue, mais bien d'une question de filiation.

génétique[695]. L'expérience et les règles que l'on connaît sont fondées sur une réalité différente, l'unicité et l'indivisibilité de la maternité ; leur application à la maternité de substitution suppose des choix mieux informés. Laisser cette nouvelle réalité évoluer devant nos tribunaux et dans la société avant d'imposer une règle nous semble être la solution la plus juste[696]. À ce stade, l'intérêt de l'enfant serait mieux protégé par l'appréciation judiciaire des circonstances de chaque cas. Le statut quo laisse ici la porte ouverte à l'exercice des pouvoirs discrétionnaires judiciaires, souvent essentiel à la résolution des conflits.

Il n'y a donc pas lieu pour le moment de consacrer législativement, en matière de maternité de substitution, la règle attribuant la maternité légale à la femme qui accouche.

II. La procréatique et la sécurité

À la lumière des chapitres précédents, nous pouvons conclure que la procréation médicalement assistée soulève de sérieuses questions sur le plan de la sécurité des personnes qui y ont recours et des enfants qui en sont issus. Parmi les problèmes soulevés, signalons les taux de succès peu élevés, les variations importantes dans la façon d'établir et d'interpréter ces taux, les risques physiques et psychologiques, le manque d'uniformité dans la tenue des dossiers et la pénurie de données nationales.

A. Les taux de succès : l'importance du consentement éclairé

La confusion qui entoure les taux de succès de certaines techniques nous amène à nous interroger sur la capacité des couples infertiles de choisir celle qui leur convient le mieux[697]. En effet, les différentes façons de calculer les taux de succès[698] rendent très difficile l'interprétation pourtant nécessaire à la formulation d'un consentement éclairé[699].

En outre, les taux de succès disponibles en matière d'insémination artificielle reposent sur des études qui, pour la plupart, ont été réalisées avec du sperme non congelé[700]. Ces taux de succès ne sont donc plus concluants puisque des études ont déjà démontré que

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695. Voir cependant la loi modifiant la loi uniforme sur le statut de l'enfant, précitée, note 203, art. 11.3 et 11.4 ; voir *supra*, note 328.

696. À cet égard, voir *Anna J.* c. *Mark C.*, précité, note 327. Rappelons que, dans ce litige, M[me] Johnson a été la première femme porteuse à réclamer des droits parentaux et la garde d'un enfant auquel elle n'est pas génétiquement liée.

697. Voir *supra*, pp. 7, 16-18.

698. *Ibid.* Louise VANDELAC, « La face cachée de la procréation artificielle » (1989), 213 *La Recherche* 1112, 1114 : « Alors que dans l'opinion publique, le taux succès (sic) de la FIVETE mesure la probabilité à chaque tentative d'avoir un enfant, les équipes bio-médicales ont tendance à n'y voir que leur propre taux de réussite dans certaines phases de la technique.

Ces taux de succès fluctuent autant que les méthodes de calcul. »

699. Voir *supra*, pp. 69-70, au sujet de la nécessité du consentement libre et éclairé.

700. Voir *supra*, pp. 32-33.

la congélation du sperme, rendue nécessaire aujourd'hui afin d'éviter notamment la transmission du sida, réduit de moitié la motilité, la longévité et la capacité de fécondation des spermatozoïdes[701]. De nouvelles études devraient donc être entreprises afin de présenter aux couples infertiles des taux de succès plus réalistes.

En matière de fécondation in vitro et d'implantation tubaire de gamètes, nous avons montré au chapitre premier la complexité et le manque d'uniformité qui caractérisent la façon de compiler les résultats obtenus. Puisque la détermination du taux de réussite varie selon le numérateur et le dénominateur choisis, il n'est pas surprenant que les taux déclarés sèment la confusion et se prêtent mal à la comparaison.

Étant donné les taux de réussite très faibles de la fécondation in vitro[702] et la vulnérabilité des couples infertiles (pour qui la procréation médicalement assistée représente très souvent la dernière chance de concevoir un enfant), il est très important que les couples qui choisissent de recourir à cette technique, comme à ses dérivés et à ceux de l'implantation tubaire de gamètes, soient à même de donner un consentement libre et éclairé. Pour ce faire, il y aurait lieu d'imposer aux cliniques l'obligation de compiler de façon uniforme les résultats obtenus, afin qu'il soit possible d'avoir facilement accès à des statistiques fiables[703].

Afin de permettre une appréciation complète de ces résultats, il est donc important que le contenu des rapports cliniques soit normalisé[704]. Les statistiques devraient indiquer non seulement le nombre de grossesses ou d'enfants obtenus mais également les grossesses extra-utérines, les avortements spontanés, le nombre d'embryons transférés, le taux de grossesse multipare, le taux de malformations congénitales et les autres problèmes possibles[705].

Sur un autre plan, l'analyse des données à l'échelle nationale permettrait la compréhension des problèmes que soulève, pour notre société et pour les personnes qui

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701. *Ibid.*

702. Voir *supra*, pp. 18-20.

703. Nous estimons qu'il s'agit d'une réaction mesurée lorsqu'on la compare avec les poursuites intentées récemment par les autorités américaines contre des cliniques qui auraient fait une promotion inéquitable et trompeuse de leur taux de réussite. Voir Proposed Consent Agreement with Analysis to Aid Public Comment, précité, note 566 ; *Federal Trade Commission* c. *Jacobson*, précité, note 566. Comparer avec *R.* c. *Gregory*, précité, note 565.

704. Voir *supra*, p. 18.

705. Voir *supra*, p. 20 et suiv. Au sujet des taux de succès et d'un besoin de contrôle à l'échelle nationale, L. VANDELAC, *loc. cit.*, note 693, 1116, écrit :

> On s'étonne [...] que la notion de taux de succès ne soit pas redéfinie de façon homogène en fonction du nombre d'enfants conçus par FIV et en santé à l'âge d'un mois, comparé au nombre total d'inductions d'ovulation. Ceci diminuerait la contribution des transferts multiples dans les taux de succès et conduirait à reconsidérer les transferts multiples et la FIV elle-même.
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> Certains rapports comme celui de l'Australie, de Wagner de l'OMS ou le récent avis du Conseil du statut de la femme au Québec vont dans ce sens et réclament un encadrement plus serré de la fécondation artificielle, ainsi que la redéfinition et la transparence des données statistiques, mais les pouvoirs publics semblent lents à réagir.

y ont recours, la procréation médicalement assistée. Le manque d'uniformité dans la façon de calculer les taux de succès et l'indigence des statistiques en général ne permettent pas une évaluation adéquate de la situation actuelle. À l'obligation de compiler de façon uniforme les résultats obtenus par les cliniques, nous devons ajouter la nécessité de centraliser ces données et de les analyser à l'échelle nationale. La normalisation et la centralisation des données afférentes à l'activité des cliniques ainsi que leur analyse sont, en effet, essentielles puisqu'elles rendent possible le contrôle des méthodes. La mise sur pied d'un registre national pourrait combler ce besoin.

Un registre national volontaire et confidentiel a déjà été établi par un groupe de professionnels de la santé. Mais précisément parce qu'il est tributaire de la bonne volonté des intervenants, son fonctionnement soulève d'importants problèmes qui, dans les faits, le rendent presque inutile[706].

Afin que des rapports cliniques soient disponibles, que ces données soient centralisées et analysées et servent à la production de rapports statistiques fiables, et afin que l'accès à ces statistiques soit possible, les cliniques devraient être tenues de présenter un rapport annuel écrit à un registre central dont l'administration relèverait d'un organisme administratif dont nous reparlerons plus loin. Comme nous l'avons expliqué, ce rapport devrait contenir des données quant à l'application de toutes les techniques de procréation médicalement assistée, et la façon de compiler ces données devrait être normalisée, c'est-à-dire que le contenu minimal du rapport et les modalités de présentation des données devraient être déterminés. Les rapports statistiques produits à partir de ces rapports cliniques devraient être accessibles au public.

RECOMMANDATION

9. Les cliniques offrant des services de procréation médicalement assistée devraient avoir l'obligation de présenter un rapport annuel écrit à un registre central, le contenu minimal du rapport et les modalités de présentation des données étant déterminés.

B. Les risques en jeu

1. Les risques physiques

Les principaux risques que comporte l'utilisation des gamètes d'un tiers sont la transmission de maladies infectieuses et génétiques, ainsi que la consanguinité si le sperme d'un même donneur est trop souvent utilisé[707].

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706. Voir *supra*, p. 20.

707. Voir *supra*, note 166 ; voir également *supra*, note 185.

Le risque de transmission de maladies génétiques et infectieuses diminue sensiblement lorsque le donneur a été soumis à des examens approfondis et que ses gamètes ont fait l'objet d'un dépistage adéquat[708]. Il est donc important non seulement que des normes de dépistage et de sélection soient établies mais encore qu'elles soient uniformément appliquées. Or, contrairement au don de sang[709], le don de gamètes et d'embryon ne fait présentement l'objet d'aucune réglementation à l'échelle nationale[710].

Pourtant, la nécessité de normes nationales a été soulignée dans l'un des premiers rapports canadiens sur la procréation médicalement assistée[711]. De plus, en 1981, dans un rapport présenté au ministre de la Santé nationale et du Bien-être social, sur la question du stockage et de l'utilisation du sperme humain, on recommandait « que des règlements gouvernant les normes d'acquisition, de préservation et d'importation du sperme humain soient établis au niveau fédéral[712] ». Or, aucune mesure législative n'a suivi ; il n'existe que les lignes directrices élaborées par divers organismes[713].

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708. Voir *supra*, pp. 7, 32, 37 et suiv.

709. La *Loi sur les aliments et drogues*, précitée, note 301, et ses règlements établissent des normes concernant, entre autres, la publicité, l'étiquetage, la vente, l'importation, le traitement, l'entreposage et le nombre de dons permis. La Société canadienne de la Croix-Rouge a également élaboré des normes sur certains de ces sujets. Voir *Prélèvement et utilisation médicale de tissus et d'organes humains*, *op. cit.*, note 254.

710. Voir *supra*, pp. 71-72.

711. BRITISH COLUMBIA ROYAL COMMISSION ON FAMILY AND CHILDREN'S LAW, *op. cit.*, note 474, p. 33 :

> [TRADUCTION]
>
> À titre de mesure de protection globale à l'intention de tous les intéressés, nous estimons que la Direction générale de la protection de la santé, Santé et Bien-être social Canada, devrait être chargée d'*élaborer des normes* et de contrôler la sécurité de l'ensemble du processus de prélèvement, de traitement, d'entreposage, d'emballage et de distribution du sperme, tout comme s'il s'agissait d'un produit pharmaceutique.
>
> Comme le sperme n'entre dans aucune des catégories que sont les aliments, les drogues et les « instruments », et qui relèvent, aux termes de la loi, du mandat de la Direction, le législateur fédéral devra sans doute intervenir pour attribuer expressément ces responsabilités à la Direction [mis en italiques par nos soins].

La dernière recommandation du rapport est rédigée comme suit :

> [TRADUCTION]
>
> La Direction de la protection de la santé, Santé et Bien-être social Canada, devrait être chargée de contrôler l'activité des banques de sperme humain et les opérations connexes telles que le prélèvement, le traitement et la distribution, ainsi que la tenue des dossiers. Les *textes législatifs fédéraux* nécessaires à cette fin devraient être élaborés [mis en italiques par nos soins].

712. *Rapport sur le sperme humain de 1981*, *op. cit.*, note 149, p. xii.

713. Voir à titre d'exemple la SOCIÉTÉ CANADIENNE DE FERTILITÉ ET D'ANDROLOGIE, *op. cit.*, note 11. Ces lignes directrices concernent, entre autres, la sélection des donneurs et le dépistage génétique. Toutefois, voir *supra*, note 303 et le texte qui l'accompagne. D'autre part, comme nous l'avons déjà signalé, il est à craindre que, puisqu'elles n'ont pas force de loi, ces lignes directrices ne soient pas toujours suivies : *supra*, pp. 37-38. Voir également *supra*, pp. 72-72. Rona ACHILLES, « Donor Insemination: The Future of a Public Secret », dans C. OVERALL (dir.), *op. cit.*, note 130, p. 105, à la page 111 :

> [TRADUCTION]
>
> La sélection des donneurs de sperme a pris une importance manifeste avec l'apparition du syndrome immuno-déficitaire acquis (sida). Plusieurs lignes directrices ont été émises à ce sujet par les corporations professionnelles médicales. Pourtant, à la lumière de ma propre étude et d'un sondage plus vaste auprès des médecins américains, il semble que la plupart d'entre eux ne suivent pas les lignes directrices en question : seulement 44 pour 100 ont déclaré qu'ils faisaient faire les analyses de dépistage du virus VIH.

L'incertitude quant à l'application de critères uniformes de sélection, de dépistage et de conservation rend difficile le contrôle, pourtant essentiel, de la qualité[714] des gamètes et embryons utilisés pour la procréation médicalement assistée. La sélection des donneurs et de leurs gamètes, ainsi que les conditions de conservation, comportent une importante question de sécurité tant pour la mère que pour l'enfant à naître, qui sont tous les deux dans l'impossibilité de se protéger eux-mêmes contre de tels risques[715].

RECOMMANDATION

10. Des normes contraignantes et uniformes de sélection, de dépistage et de conservation à l'égard des donneurs, des gamètes et des embryons devraient être élaborées à l'échelle nationale.

Puisque l'utilisation du sperme frais comporte le risque non négligeable de transmission de certaines maladies telles que le sida, et qu'il est nécessaire de tenir compte de la période de latence de ces maladies pour que le dépistage soit efficace, il est important que le sperme donné soit congelé et que le donneur fasse l'objet d'analyses adéquates[716]. Certes, les inconvénients d'une telle politique sont évidents. D'une part, elle force les cliniques et les banques à compter des délais importants dans l'utilisation du sperme donné et, d'autre part, elle les oblige à répéter les analyses nécessaires après chaque don de sperme. De plus, cette politique empêche l'utilisation du sperme frais en matière de fécondation in vitro, d'implantation tubaire de gamètes et d'insémination artificielle hétérologue, et diminue, de ce fait, le taux de réussite de ces techniques. Malgré tout, la Commission est d'avis que le sperme donné qui est utilisé par les cliniques devrait obligatoirement être congelé, que les cliniques et les banques qui recrutent des donneurs devraient être tenues de soumettre ceux-ci à des épreuves de dépistage des maladies en question[717]. Ces exigences se rapprochent d'ailleurs du régime existant en matière de dons de sang.

RECOMMANDATION

11. Le sperme donné devrait être congelé et ne devrait être utilisé pour la fécondation qu'après que le donneur aura été soumis à des analyses adéquates pour le dépistage du virus du sida.

La congélation des gamètes et des embryons pose cependant certains problèmes. D'une part, la science ne connaît pas encore très bien les effets de la cryoconservation prolongée.

Achilles renvoie à son ouvrage, *The Social Meanings of Biological Ties: A Study of Participants in Artificial Insemination by Donor*, thèse de doctorat, Université de Toronto, 1986 ; M. CURIE-COHEN, L. LUTTRELL et S. SHAPIRO, *loc. cit.*, note 285, 585-590 ; *Artificial Insemination: Practice in the United States*, *op. cit.*, note 185, p. 37.

714. Le terme « qualité » doit s'entendre ici du point de vue de la sécurité et non dans une perspective eugénique.

715. À l'évidence, les différents organismes et corporations professionnelles devront collaborer à l'élaboration de ces normes établies dans l'intérêt public.

716. Voir *supra*, pp. 32, 37 et suiv.

717. Voir *infra*, annexe A, pp. 201-203.

D'autre part, le principe des générations risque de s'en trouver bouleversé puisque l'embryon pourrait, en théorie, être réimplanté après une très longue période de congélation. Ces difficultés ont poussé certains pays à limiter la période de congélation[718].

Consciente de ce que les restrictions de cette nature sont, dans l'état actuel des connaissances, tout à fait arbitraires[719], la Commission juge néanmoins important, du point de vue de la sécurité et dans une perspective sociologique, de limiter la période de congélation. Au moment de déterminer la limite à imposer, il importe de prendre en considération le fait qu'un délai trop court obligerait les femmes à s'exposer plus fréquemment aux risques et inconvénients de la stimulation ovarienne et du prélèvement d'ovocytes, ou encore à accepter le transfert d'un nombre plus élevé d'embryons à chaque cycle, avec les risques que cela comporte. Pour l'instant, la Commission réitère la position qu'elle a déjà adoptée dans son document de travail sur l'expérimentation[720] et recommande un délai de cinq ans. Toutefois, il nous paraît souhaitable que des recherches plus approfondies soient entreprises à l'échelle nationale sur toute cette question et, en particulier, sur les effets de la cryoconservation. La responsabilité de ces recherches pourrait être confiée à un organisme central dont nous parlerons plus loin.

RECOMMANDATION

12. (1) L'embryon ne devrait pas pouvoir être congelé pendant plus de cinq ans. Les autorités fédérales devraient encourager les recherches sur les effets de la cryoconservation afin que cette limite puisse être réévaluée.

À la différence des embryons, les gamètes peuvent être déposés et congelés avant même l'existence d'un projet parental puisque le motif de leur congélation peut être l'infertilité éventuelle d'une personne qui doit subir un traitement médical ou une intervention chirurgicale[721]. Compte tenu de cette réalité, une limite de dix ans nous semble plus judicieuse[722]. Les remarques que nous avons faites précédemment concernant le besoin de recherches plus approfondies sur les effets de la cryoconservation s'appliquent également ici.

RECOMMANDATION

12. (2) Les gamètes ne devraient pas pouvoir être congelés pendant plus de dix ans. Les autorités fédérales devraient encourager les recherches sur les effets de la cryoconservation afin que cette limite puisse être réévaluée.

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718. Voir *infra*, annexe A, Tableau III pp. 217-220.

719. *L'expérimentation biomédicale sur l'être humain*, *op. cit.*, note 7, p. 59.

720. *Ibid.* Voir au même effet : la loi n° 35/1988 du 22 novembre sur les techniques de reproduction assistée, art. 11 (Espagne) ; CONSEIL D'ÉTAT, *op. cit.*, note 668 ; *Human Fertilisation and Embryology Act 1990*, précité, note 425, art. 14 ; White Paper, *op. cit.*, note 658, p. 9 ; ASSOCIATION DU BARREAU CANADIEN, *op. cit.*, note 281, pp. 33-37. Pour plus de détails, voir *infra*, annexe A, pp. 201-203 et le tableau III.

721. Voir *supra*, p. 32.

722. Voir *Human Fertilisation and Embryology Act 1990*, précité, note 425, art. 4, 14 ; White Paper, *op. cit.*, note 658, p. 9.

Par ailleurs, dans le but de réduire les risques de consanguinité, il est important aussi de limiter le nombre de fois que les gamètes d'un même donneur peuvent être utilisés[723].

Toutefois, comme ces risques peuvent varier en fonction de divers facteurs tels que la densité et la mobilité de la population servie par la clinique ou la banque, la limite fixée devrait être suffisamment souple pour en tenir compte. Des études devront donc être entreprises à cet égard.

RECOMMANDATION

13. Le nombre de fois que les gamètes d'un même donneur peuvent être utilisés devrait être limité. Les études nécessaires devraient être encouragées afin que cette limite puisse être adéquatement fixée.

Enfin, nous avons déjà mentionné que certaines cliniques importent des gamètes des États-Unis[724]. L'existence d'une circulation internationale soulève la question de la suffisance des normes appliquées à l'étranger. Il est donc essentiel de s'assurer que les gamètes et embryons importés répondent également aux normes canadiennes[725].

RECOMMANDATION

14. L'importation des gamètes et des embryons devrait être réservée aux banques accréditées. Les gamètes et les embryons importés devraient répondre aux normes canadiennes.

La fécondation in vitro et l'implantation tubaire de gamètes posent des risques particuliers dont la plupart sont liés à la stimulation ovarienne et à la grossesse multiple[726].

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723. Voir *supra*, p. 33. En matière de droit comparé, voir *infra*, annexe A, p. 203.

724. Voir *Rapport sur le sperme humain de 1981*, *op. cit.*, note 149, p. 14.

725. Il est possible que certains produits génétiques soient visés par la *Loi sur les aliments et drogues*, précitée, note 301. Cependant, l'incertitude quant à l'inclusion des gamètes et embryons et le besoin de normes spécifiques requièrent une intervention plus précise. Voir à ce sujet et au sujet de l'application de la *Loi sur la quarantaine*, précitée, note 562, art. 5 et du *Tarif des douanes*, L.R.C. (1985), ch. 41 (3e suppl.), *Prélèvement et utilisation médicale de tissus et d'organes humains*, *op. cit.*, note 254. Il apparaît à tout le moins surprenant qu'en matière de produits génétiques animaux cet aspect soit bien réglementé alors que pour les gamètes et embryons humains il n'existe aucune réglementation. À titre d'information, il est intéressant de noter que, l'année dernière, le Canada a exporté plus de 1 200 embryons animaux congelés et 2 millions de doses de sperme animal en application d'un régime réglementaire national. Ce régime prévoit l'octroi de permis à quelques 48 services nationaux de transfert aux fins de reproduction et impose des permis pour l'importation et l'exportation de gamètes fécondés et non fécondés. Au mois de juin dernier, le Parlement a mis à jour ce régime de contrôle des maladies dans la *Loi sur la santé des animaux* (précitée, note 564). Voir le *Règlement sur les maladies et la protection des animaux*, précité, note 564, art. 32, 50, 59, 84, 115, dont l'application a été confiée à Agriculture Canada aux termes de la *Loi sur les maladies et la protection des animaux*, remplacée par la *Loi sur la santé des animaux* (précitées, note 564, art. 2, 14, 16, 19).

726. Il a été mentionné (*supra*, pp. 20-21) que les taux d'avortement spontané, de grossesse multiple, de grossesse extra-utérine et de césarienne sont sensiblement plus élevés dans le contexte de la procréation médicalement assistée que dans la population en général.

Le taux de grossesse multipare présente ici un intérêt particulier puisqu'il soulève la question de l'opportunité de limiter le nombre d'embryons implantés ou d'ovules fécondés au cours d'un même cycle. Nous avons montré au début de notre étude que, si le transfert de plus d'un embryon augmente les chances de grossesse, il augmente également les risques de grossesse multipare. Devant l'importance des risques associés à celle-ci[727], la limitation du nombre d'embryons implantés au cours d'un même cycle semble s'imposer[728]. Pourtant, il est loin d'être certain qu'une telle limite aiderait à réduire le taux de grossesse multiple. Rappelons en effet que le nombre d'embryons transférés n'est pas le seul facteur qui détermine les chances de grossesse et les risques de grossesse multiple. Nous avons vu que le transfert de trois embryons peut en fait donner lieu à un taux de grossesse multipare plus élevé que le transfert de quatre[729]. Il est donc essentiel qu'une plus grande importance soit accordée aux circonstances de chaque cas (âge de la femme, multiparité, etc.). Une limite arbitraire ne saurait atteindre le but ici poursuivi, soit la sécurité de la mère et des enfants à naître.

On ne saurait trop espérer la mise au point de techniques ne nécessitant pas la stimulation ovarienne et qui, de ce fait, élimineraient les risques reliés aux médicaments inducteurs de l'ovulation et permettraient de diminuer les risques de grossesse multiple. En attendant des résultats plus concluants, une importance primordiale doit être attachée à la réduction du taux de grossesse multipare.

RECOMMANDATION

15. Il y aurait lieu de tout mettre en œuvre pour réduire les risques de grossesse multiple et favoriser la mise au point de techniques reposant sur le cycle normal d'ovulation. À cette fin, les autorités fédérales devraient encourager les études et la recherche visant à réduire le taux de grossesse multiple et à perfectionner les techniques ne nécessitant pas la stimulation ovarienne. En outre, les cliniques devraient avoir l'obligation d'enregistrer et de motiver le nombre d'embryons implantés au cours de chaque cycle de traitement.

2. Les risques psychologiques

Les faux espoirs fondés sur des taux de succès peu représentatifs, l'inefficacité marquée de certaines techniques, les répercussions des différentes étapes de la fécondation in vitro et de l'implantation tubaire de gamètes, de même que l'intervention génétique d'une tierce personne, sont autant de risques psychologiques non négligeables pour les personnes qui choisissent de recourir à la procréation médicalement assistée.

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727. Voir *supra*, pp. 21-23.

728. Voir *supra*, p. 24 et suiv. L'Interim Licensing Authority du Royaume-Uni et le Reproductive Technology Accreditation Committee de l'Australie ont mis en application des recommandations à l'effet de limiter à trois ou, dans des cas extrêmes, à quatre le nombre d'embryons qui peuvent être implantés au cours d'un même cycle.

729. Voir *supra*, p. 24.

Derrière les faibles taux de succès se cachent en effet les douleurs et angoisses des patients dont les efforts sont demeurés vains[730]. De plus, le coût élevé de certains traitements, les souffrances physiques qu'ils imposent et la succession d'opérations qu'ils comportent sont également des sources de tension et d'anxiété[731].

Enfin, l'intervention d'un tiers donneur dans la formation d'une unité familiale peut également comporter des risques psychologiques pour les futurs parents et l'enfant à naître. La tension psychologique qu'engendre le secret, les conséquences d'une divulgation non préparée, les frustrations éventuelles du père envers l'enfant et la mère (si elle a un lien biologique avec l'enfant), ainsi que les problèmes d'identité que l'enfant peut éprouver, ne sauraient être minimisés. Le besoin d'assistance va donc au-delà de l'aide médicale à la conception. Étant donné la fragilité des personnes aux prises avec un diagnostic d'infertilité (souvent après des années de tentatives et d'investigation du problème) et la difficulté des choix qui se présentent, il est primordial que ces personnes soient particulièrement bien informées des difficultés qui les attendent. Afin d'être en mesure de prendre des décisions libres et éclairées, elles devraient avoir la faculté de consulter des experts (médecins, psychologues, etc.) que ce soit au sujet des risques, tant physiques[732] que psychologiques, ou des taux réels de succès, et ce, avant, pendant et après l'application d'une technique de procréation médicalement assistée. Les cliniques qui offrent des services en matière de procréation médicalement assistée devraient donc avoir l'obligation d'offrir aussi des services de consultation[733]. Nous reviendrons sur cette question dans le contexte de l'accréditation des cliniques.

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730. Au sujet de la notion de taux de succès, L. VANDELAC (*loc. cit.*, note 698, 1115) écrit : « Elle camoufle [...] l'angoisse et la douleur de celles qui subissent ces fausses-couches, grossesses extra-utérines et morts foetales avec leur cortège de risques, de douleurs, d'espoirs déçus, de complications et d'hospitalisations ». Carolyn M. MAZURE et Dorothy A. GREENFELD, « Psychological Studies of In Vitro Fertilization/Embryo Transfer Participants » (1989), 6:4 *J. In Vitro Fert. Embryo Transfer* 242, 248 : [TRADUCTION] « L'autre phénomène émotif le plus fréquent semble être la réaction de détresse qui fait suite à l'échec du traitement. » Voir également la p. 250 à ce sujet ; au sujet de l'attitude et des sentiments que génèrent l'infertilité, voir *id.*, 243-244 :

> [TRADUCTION]
> Freeman et ses collègues ont révélé que, au cours des entretiens préalables au traitement, sur 200 couples candidats à la FIVETE, 49% des femmes et 15% des hommes ont déclaré que l'infertilité avait été l'épreuve la plus affligeante de leur vie, en comparaison d'autres pertes comme la mort ou d'autres facteurs de tension comme le divorce. Mahlstedt et ses collègues, pour leur part, ont demandé aux participants à la FIVETE de remplir un questionnaire et de le retourner par la poste à la fin du cycle de traitement ou au moment de la confirmation de la grossesse. Dans le cadre de cette étude, on a également demandé aux participants de comparer la tension provenant de l'infertilité, de la mort et du divorce. De ceux qui avaient vécu un divorce ou la perte d'un ami ou d'un membre de leur famille, [...] 63% ont déclaré que l'infertilité avait été aussi éprouvante, sinon davantage, que le divorce, et 58% ont affirmé que l'infertilité était à tout le moins aussi affligeante que la perte d'un être cher.

731. C.M. MAZURE et D.A. GREENFELD, *loc. cit.*, note 730, 248, 249.

732. Voir *supra*, p. 20 et suiv.

733. Voir *supra*, p. 27. En Nouvelle-Galles du Sud, la consultation est obligatoire ; voir *infra*, annexe A, p. 204 et suiv. La rec. 19 du Rapport Warnock (*op. cit.*, note 425, p. 132) prévoit que : « la consultation d'un conseiller soit proposée à tous les couples stériles et aux parties tiers à tout stade du traitement, aussi bien comme partie intégrante du service offert par le NHS [National Health Service] que dans le secteur privé. » Les lignes directrices de l'ASSOCIATION DES MÉDECINS DE L'ONTARIO (*loc. cit.*, note 86, 28), contiennent une disposition d'ordre général au sujet de la nécessité de services de consultation : [TRADUCTION] « Il y a

RECOMMANDATION

16. Toute clinique qui offre des services en matière de procréation médicalement assistée devrait avoir l'obligation d'offrir aux personnes qui y ont recours, et ce, avant, pendant et après l'application d'un traitement, des services de consultation permettant à ces personnes d'obtenir auprès d'experts (médecins, psychologues, etc.) l'aide et l'information dont elles peuvent avoir besoin au sujet des problèmes particuliers de la procréation médicalement assistée.

C. La tenue des dossiers

Essentielle à la réglementation[734], à la compilation de statistiques et à la réalisation d'études sur les effets à long terme des différentes techniques, la tenue de dossiers médicaux adéquats est extrêmement importante pour la santé physique et psychologique de l'enfant. L'information médicale concernant le patrimoine génétique de l'enfant peut, en effet, être essentielle à l'efficacité des soins médicaux dispensés à l'enfant. Cette information doit donc être conservée et accessible[735].

Toutefois, la tenue de dossiers et l'accès à l'information qu'ils contiennent posent la question du respect de la vie privée des parties, de leur droit à l'anonymat. L'information relative à l'identité des parties devrait donc être conservée de façon indépendante du dossier médical. Un système permettant au médecin de relier le donneur ou la donneuse à la receveuse, et, du même coup, à l'enfant ainsi conçu, devrait être mis sur pied par les cliniques. Un tel système rendrait possible l'accès à l'information médicale et génétique nécessaire sans toutefois porter atteinte au droit à la vie privée des intéressés[736]. Toujours au nom de ce droit, l'information recueillie devrait être limitée à ce qui est nécessaire à la poursuite des objectifs motivant la tenue des dossiers, et les cliniques devraient garantir la confidentialité de l'information qu'elles ont en leur possession[737].

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lieu d'apporter une attention particulière aux besoins et au soutien émotifs des couples et de leurs familles. Chez de nombreux couples, la fécondation in vitro n'est pas la solution à l'infertilité. Des services de consultation devraient donc être offerts pour permettre à ces couples d'envisager des solutions de rechange. »

734. B.M. KNOPPERS et E. SLOSS, *loc. cit.*, note 272, 681 : [TRADUCTION] « Afin de coordonner et de contrôler efficacement la sélection des gamètes, il est nécessaire d'établir un système de dossiers complets et permanents permettant de relier entre eux les enfants, donneurs et receveuses. » Un tel système permettrait également de retracer les gamètes contaminés, les personnes qui les ont donnés et celles qui les ont reçus.

735. Voir la rubrique « Le droit d'être informé de ses origines biologiques », *supra*, p. 99. À la p. 100, nous avons mentionné que le refus de divulguer des renseignements nécessaires à la préservation de la vie et de la santé constituait une atteinte au droit à la sécurité de la personne conçue grâce à la procréatique. Voir également l'art. 583 du projet de loi 125, précité, note 200.

736. Au sujet des diverses positions préconisées dans le monde, voir *infra*, annexe A, pp. 205-207.

737. La loi modifiant la loi uniforme sur le statut de l'enfant (précitée, note 203, art. 11.2) contient certaines dispositions à ce sujet. Ces dispositions rendent les médecins responsables de la tenue des dossiers mais c'est un registre central qui rendrait possible l'accès aux dossiers qui peuvent être reliés. Le responsable de la confidentialité de cette information est ici l'organisme qui la reçoit.

L'information identifiante[738] et l'information d'ordre social[739] peuvent, pour leur part, s'avérer importantes pour le bien-être psychologique de l'enfant. C'est là toute la question du droit de l'enfant de connaître les origines de sa naissance et l'identité de ses géniteurs[740]. Comme nous l'avons vu[741], cette question ne nous est pas tout à fait inconnue. En matière d'adoption, certaines provinces ont mis sur pied des systèmes permettant aux enfants adoptifs de rechercher leurs parents biologiques[742]. Il est maintenant bien reconnu que la possibilité de retrouver ses parents biologiques, ou du moins de savoir qui ils sont, répond à un besoin psychologique important chez les personnes adoptées. Or, il existe une analogie certaine entre la situation de celles-ci et celle des enfants issus de gamètes donnés.

Certes, l'intérêt que peut avoir l'enfant à connaître ses origines entre, en premier lieu, en conflit avec le droit à la vie privée des parents. Imposer aux parents le devoir de divulguer à l'enfant l'origine de sa naissance pourrait en effet être perçu comme un empiètement inconstitutionnel sur le droit fondamental des parents de prendre les décisions qu'ils jugent bien fondées concernant la façon d'élever leurs enfants. De plus, l'intérêt de l'enfant est ici très difficile à déterminer de façon objective. Comme le soulevait la CRDO, [TRADUCTION] « Les répercussions sociales et psychologiques de la divulgation sont tout simplement obscures ; il est impossible d'en prédire les effets précis dans chaque cas individuel[743]. » La décision doit être laissée à la discrétion des intéressés, à la lumière de la personnalité et des besoins de chaque enfant[744].

En second lieu, l'intérêt de l'enfant entre aussi en conflit avec l'intérêt du donneur à conserver l'anonymat. Ce conflit exige la poursuite d'un équilibre entre le droit à la vie privée du donneur et le droit de l'enfant de connaître ses origines.

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738. L'information identifiante doit de toute façon être conservée puisqu'elle est essentielle pour établir la responsabilité éventuelle du donneur.

739. Celle-ci peut porter notamment sur l'origine ethnique, la profession, le niveau d'instruction, l'appartenance religieuse et les centres d'intérêt. Voir à titre d'exemple, MINISTÈRE DES SERVICES SOCIAUX ET COMMUNAUTAIRES, *Services de divulgation des renseignements sur les adoptions*, Toronto, le Ministère, 1987, p. 6.

740. Lori B. ANDREWS, « Legal and Ethical Aspects of New Reproductive Technologies » (1986), 29:1 *Clin. Obstet. Gynecol.* 190, 198 : [TRADUCTION] « Certaines personnes conçues par insémination artificielle et âgées maintenant d'une vingtaine ou d'une trentaine d'années estiment avoir éprouvé des troubles émotifs en raison du fait qu'elles ont été conçues au moyen du sperme d'un donneur. À l'instar des enfants adoptés, elles éprouvent le besoin, pour leur bien-être psychologique et physiologique, de connaître d'une façon ou d'une autre le donneur, leur père biologique. » Dans le même sens, voir R. ACHILLES, *loc. cit.*, note 713, 110.

741. Voir *supra*, pp. 67, 68, 99 et suiv.

742. Voir *supra*, pp. 67-68 et note 284.

743. *Op. cit.*, note 2, p. 187.

744. Même en Suède, où le droit de connaître ses origines est reconnu à l'enfant, la divulgation est laissée à la discrétion des parents.

> Dans les travaux préparatoires de la nouvelle loi, il est constaté d'emblée qu'il importe que les parents aient une attitude franche et ouverte envers l'enfant. Les parents doivent par conséquent, dès que le moment semble venu, dire à l'enfant comment il a été conçu. Il n'a pas été jugé opportun de régler cette question par voie légale ; au lieu de cela, il est souligné que le médecin, lors de la consultation psycho-sociale qui précède l'insémination, doit s'employer à faire comprendre aux futurs parents l'importance de la franchise envers l'enfant.

Göran EWERLÖF, « L'insémination artificielle — Législation et débat » (1985), 329 *Actualités Suédoises* 1, 7.

Si l'information identifiante doit être conservée (parce qu'essentielle à l'établissement de la responsabilité éventuelle du donneur), sa divulgation ne pourrait toutefois avoir lieu qu'avec le consentement du donneur au moment de la demande formulée par l'enfant[745].

L'information d'ordre social non identifiante devrait en revanche pouvoir être divulguée sur simple demande de l'enfant ou des parents. En effet, la communication de ces renseignements d'ordre général, importante pour le développement psychologique de l'enfant, ne compromet en rien la vie privée du donneur[746].

RECOMMANDATIONS

17. (1) Les cliniques devraient être tenues de maintenir des dossiers (concernant le donneur ou la donneuse, la receveuse et l'enfant) permettant au médecin de relier le donneur ou la donneuse à la receveuse, tout en garantissant l'anonymat des parties.

(2) L'information recueillie devrait être limitée à ce qui est nécessaire à la poursuite des objectifs suivants : permettre l'accès à l'information médicale et génétique qui pourrait être nécessaire à l'efficacité des soins médicaux dispensés à l'enfant ; satisfaire les besoins psychologiques de l'enfant ; permettre une préparation adéquate des rapports cliniques et entreprendre des études sur les effets à long terme des différentes techniques de procréation médicalement assistée.

(3) Les cliniques devraient être garantes de la confidentialité de l'information qu'elles ont en leur possession.

18. À la demande des parents légaux ou de l'enfant, l'information non identifiante, notamment l'information d'ordre social (comme l'origine ethnique, la profession, le niveau d'instruction, l'appartenance religieuse et les centres d'intérêt du donneur ou de la donneuse), devrait pouvoir être divulguée. En revanche, l'information identifiante ne devrait pouvoir être divulguée que si le donneur ou la donneuse y consent.

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745. Signalons qu'en Suède, si l'adoption d'une loi qui reconnaissait à l'enfant le droit de connaître ses origines a initialement donné lieu à une baisse importante du nombre de donneurs, il n'a fallu que quelques mois pour que cette situation se rectifie. R. ACHILLES, *loc. cit.*, note 713, 105-115 : [TRADUCTION] « [E]n quelques mois, le nombre de donneurs a remonté pour atteindre les niveaux antérieurs et, selon les rapports, on trouve maintenant dans les programmes un type différent de donneurs. » Voir également, dans ce sens, Bertil WENNERGREN, « Consequences of New Regulations in Reproductive Medicine and Human Embryo Research in their Relationship with Science, Ethics and Law — The Swedish Approach », dans C. BYK (dir.), *op. cit.*, note 644, p. 387, à la page 389, et Lena JONSSON, « Artificial Insemination in Sweden », dans *Sortir la maternité du laboratoire*, *op. cit.*, note 497, p. 148, à la page 154.

746. Voir *supra*, pp. 100-101. Dans la plupart des rapports récents concernant l'adoption et la procréation médicalement assistée on a recommandé que l'information non identifiante soit rendue disponible et que l'information identifiante ne soit divulguée qu'avec le consentement des parents biologiques. Voir B.M. KNOPPERS et E. SLOSS, *loc. cit.*, note 272, 693-696.

Toutefois, à la lumière de la décision récente *R.* c. *Thornton*[747], nous pouvons conclure que le donneur ou la donneuse qui, intentionnellement, cacherait des renseignements importants ou donnerait de faux renseignements pourrait faire l'objet de poursuites en application soit de l'article 180 (nuisance publique) du *Code criminel*, soit de l'article 219 (négligence criminelle)[748]. Il est donc essentiel que le nom du donneur ou de la donneuse soit conservé et que son droit à l'anonymat ne lui serve pas de défense à d'éventuelles poursuites criminelles[749].

RECOMMANDATION

19. L'identité du donneur ou de la donneuse qui omet de fournir des renseignements ou qui fournit de faux renseignements devrait pouvoir être révélée au ministère public en vue de poursuites pénales liées à cette réticence ou à cette déclaration mensongère.

D. L'évaluation à long terme

L'incertitude qui entoure les risques que comporte la procréation médicalement assistée exige qu'une certaine vigilance soit exercée. À titre d'exemple, si l'utilisation de gamètes et d'embryons congelés paraît n'avoir posé jusqu'à présent aucun problème de sécurité, la prudence nous incite à recommander que l'on continue à surveiller les conséquences à long terme de la cryoconservation sur la santé et la sécurité. De façon générale, il devrait en être de même des effets à long terme des différentes techniques sur les enfants qui en sont nés. Et pour que des études sur les effets à long terme puissent être réalisées, il est essentiel que des dossiers soient adéquatement tenus et que des données soient colligées et disponibles à l'échelle nationale[750].

RECOMMANDATION

20. Des études devraient être entreprises pour déterminer et mesurer les effets à long terme des techniques de procréation médicalement assistée sur les enfants qui en sont nés.

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747. Précitée, note 273.

748. Voir les art. 180, 216 et 219 du *Code Criminel*. Dans *R.* c. *Thornton* (précité, note 273), le juge Flanigan de la Cour de district d'Ontario écrit ce qui suit à la p. 34 de ses motifs : [TRADUCTION] « Encore une fois, je suis d'avis que le Code nous fournit au moins trois textes d'incrimination pour sanctionner les agissements de l'accusé en l'espèce ; il s'agit des dispositions traitant de la négligence criminelle ou du méfait public, et des dispositions sur lesquelles s'appuie la poursuite, c'est-à-dire celles des articles 180 et 216. »

749. Voir, dans le même sens, *Rapport sur le sperme humain de 1981*, *op. cit.*, note 149, p. 23. Pour plus de détails, voir *infra*, annexe A, p. 207.

750. Ces dernières préoccupations ont déjà fait l'objet de recommandations. Voir *supra*, rec. 9 et 17.

III. La mise en œuvre des recommandations

A. La réglementation de la pratique

Compte tenu de l'insuffisance des contrôles actuels[751] et afin de régler efficacement les différents aspects de la sécurité des citoyens, nous sommes d'avis qu'il est essentiel de réglementer certains aspects de l'activité des cliniques et des banques de gamètes et d'embryons[752]. Diverses conditions et restrictions pourraient être imposées grâce à un système d'accréditation[753]. Ainsi, l'octroi de l'accréditation serait conditionné par l'exécution de certaines obligations initiales comme la mise sur pied de services de consultation et d'un système de dossiers[754], alors que son maintien dépendrait du respect des autres normes[755], obligations[756], restrictions[757] ou interdictions[758]. De cette façon, il serait possible de vérifier, par exemple, si les cliniques et les banques observent les interdictions en matière de sélection et de commercialisation des gamètes et embryons[759]. Enfin, ce système permettrait de régler certains autres aspects délicats de la procréation médicalement assistée, comme le contenu des formules servant à exprimer la volonté des titulaires de l'autorité sur les gamètes et les embryons[760].

RECOMMANDATION

21. (1) Un système d'accréditation des cliniques et des banques de gamètes et d'embryons devrait être mis sur pied afin de réglementer, notamment, les questions suivantes :

***a*) les normes nationales de sélection et de conservation des gamètes et des embryons ;**

***b*) l'obligation de faire un rapport annuel à un registre central, de même que le contenu de ce rapport ;**

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751. Voir *supra*, p. 111 et suiv.

752. Voir la rubrique « La réglementation de la procréatique », *supra*, p. 123. Voir les recommandations concernant les normes de sélection, de dépistage et de conservation des gamètes et des embryons (rec. 10), ainsi que les recommandations qui prévoient, à l'égard des cliniques et des banques, différentes obligations (rec. 9, 11, 15 à 19), restrictions (rec. 5(4), 6(4), 12 à 14) et interdictions (rec. 2 et 3). La Commission a déjà recommandé dans son document intitulé *L'expérimentation biomédicale sur l'être humain* (*op. cit.*, note 7) qu'il conviendrait d'élaborer des normes visant la création, l'expansion et la gestion des banques de sperme et d'embryons (*id.*, rec. 8(3), p. 59).

753. Pour les effets de l'accréditation, voir notamment *supra*, la rec. 14.

754. Voir *supra*, rec. 16 et 17.

755. Normes portant par exemple sur la sélection et la conservation des gamètes et des embryons ; voir *supra*, rec. 10.

756. Voir *supra*, rec. 9, 11 et 15 à 19.

757. Voir *supra*, rec. 5(4), 6(4) et 12 à 14.

758. Voir *supra*, rec. 2 et 3.

759. Voir *supra*, rec. 2 et 3.

760. Voir *supra*, rec. 5 et 6.

c) l'obligation de congeler le sperme donné et de l'utiliser seulement après que le donneur aura été soumis à des analyses adéquates pour le dépistage du virus du sida ;

d) l'obligation de motiver par écrit le nombre d'embryons implantés au cours de chaque cycle de traitement ;

e) l'obligation d'établir des services de consultation, ainsi que la composition et les fonctions de ces services de consultation ;

f) l'obligation de tenir des dossiers médicaux, de même que le contenu de ces dossiers ;

g) l'obligation de mettre sur pied un système permettant aux médecins de relier les donneurs et les donneuses aux receveuses tout en garantissant l'anonymat des parties ;

h) les obligations concernant l'accès à l'information identifiante et non identifiante ;

i) les restrictions concernant les formes d'utilisation permises et le délai de congélation des gamètes et des embryons, la fréquence d'utilisation des gamètes d'un même donneur et l'importation des gamètes et des embryons ;

j) les interdictions concernant la sélection et la commercialisation des gamètes et des embryons ;

k) les conditions relatives au don de gamètes et d'embryon, la notion d'autorité sur ceux-ci, la façon pour le titulaire de cette autorité d'exprimer sa volonté, ainsi que la portée et les modalités d'exercice de cette volonté.

Il importe par ailleurs d'empêcher les cliniques privées de contourner les exigences du contrôle de la qualité, par exemple en utilisant du sperme frais provenant d'un réseau de donneurs qu'elles pourraient réunir, ce qui risquerait de compromettre la sécurité de la mère et de l'enfant à naître. Aussi est-il essentiel de réserver l'application des techniques de procréation médicalement assistée aux cliniques accréditées, et de punir l'exercice non autorisé de la procréatique[761]. D'autre part, il est important d'assurer le respect par les cliniques et les banques des différentes prohibitions, restrictions et obligations recommandées en réponse aux divers problèmes que pose la procréatique (par exemple, en matière de sélection, de commercialisation et d'utilisation des gamètes et des embryons)[762].

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761. Malgré son caractère moins invasif et sa nature privée, nous incluons ici l'insémination artificielle puisque, sans certaines précautions, l'enfant risque d'en souffrir. Il est en effet essentiel, comme nous l'avons déjà mentionné, que, par exemple, les donneurs soient bien sélectionnés, que le sperme fasse l'objet d'un dépistage adéquat et que l'information identifiante, médicale, génétique et sociale soit conservée. De plus, ces exigences permettent de veiller au respect des restrictions en matière de sélection des gamètes et des embryons ; voir *supra*, rec. 2. Voir aussi *infra*, annexe A, p. 208 et suiv.

762. Au même effet, voir *infra*, annexe A, p. 208 et suiv. Cette forme de contrôle ajouterait à celui exercé par les corporations professionnelles qui normalement protègent le public contre la mauvaise pratique ou la pratique illégale de la médecine, et qui fournissent des paramètres éthiques.

RECOMMANDATION

21. (2) L'application des différentes techniques de procréation médicalement assistée devrait être réservée aux cliniques accréditées. D'autre part, la conservation et l'importation des gamètes et des embryons devraient être réservées aux banques de gamètes et d'embryons accréditées.

B. La nécessité d'un organisme national

Comment mettre en œuvre toutes ces recommandations ? Que ce soit au niveau des principes, de l'administration de la justice ou de la sécurité des citoyens, la nature et l'objet des recommandations proposées exigent un contrôle central et uniforme de la procréation médicalement assistée. À l'exercice de ce contrôle de nature administrative s'ajoutent la mise en place du système d'accréditation, la réglementation, la surveillance de la pratique[763] et la mise sur pied d'un registre central. Il importe également, à l'échelle nationale, d'encourager les recherches et études jugées nécessaires et d'entreprendre des études à long terme.

Le besoin d'uniformité, que ce soit au niveau des choix sociaux, de la réglementation de la pratique ou de la procréation médicalement assistée en général, ainsi que la nécessité d'éviter les disparités régionales et le « tourisme interprovincial » exigent que les autorités fédérales, provinciales et territoriales collaborent à l'établissement d'un tel contrôle national[764].

Il est sans aucun doute souhaitable d'assurer la coordination et le contrôle de l'application des techniques de procréation médicalement assistée. Dans un pays unitaire, il serait aisé de légiférer pour créer un organisme doté des attributions nécessaires. Dans le contexte canadien, toutefois, où les compétences en jeu sont partagées entre le fédéral et les provinces, l'exercice de ce contrôle dépend de la collaboration de ceux-ci, de concert avec les intervenants du milieu.

La création d'un organisme national ayant des pouvoirs réglementaires et relevant tant du fédéral que des provinces semble la meilleure façon de donner suite à nos recommandations afin qu'elles aient l'effet désiré[765].

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763. Par exemple, veiller au respect des obligations, restrictions et prohibitions réglementaires ; voir *supra*, p. 172.

764. Sur le besoin de coopération entre les autorités fédérales et provinciales, voir à titre d'exemple le rapport de la CRDO, *op. cit.*, note 2, rec. 9 et 17(2), pp. 276-277.

765. Le Rapport Warnock (*op. cit.*, note 425, par. 13.3, p. 119) a recommandé la mise en place d'une autorité indépendante du gouvernement dotée d'un pouvoir réglementaire, la Statutory Licensing Authority. Celle-ci serait, entre autres, chargée du contrôle et de la réglementation des services d'infertilité, de la conservation des gamètes et des embryons, de la recherche, de l'accréditation et enfin d'un registre central des dossiers. L'Interim Licensing Authority a rempli les fonctions de la Statutory Licensing Authority en attendant l'adoption d'une loi instituant cet organisme. En novembre 1990, le *Human Fertilisation and Embryology Act 1990* (précité, note 425) est venu créer le Human Fertilisation and Embryology Authority (*id.*, art. 5). Cet organisme devrait être pleinement opérationnel à l'été 1991 et devrait remplacer l'Interim Licensing Authority ; voir à ce sujet l'annexe A, *infra*, p. 210.

Nous préférons cette solution à l'adoption d'une loi générale sur la procréation médicalement assistée. La création d'un organisme administratif national assurerait la souplesse nécessaire à ce domaine si complexe. Cet organisme permettrait une intervention systématique, un contrôle adéquat et la résolution des problèmes que le droit actuel ne peut régler.

Cet organisme devrait consister dans une équipe multidisciplinaire formée de personnes qualifiées. Il aurait les fonctions suivantes : protéger les citoyens ; octroyer l'accréditation ; réglementer certains aspects des activités des banques de gamètes et d'embryons, des cliniques et de la procréation médicalement assistée en général (conditions d'accréditation, modalités du consentement au don et à la conservation, etc.) ; assurer le respect des différentes obligations, normes, restrictions et prohibitions ; mettre sur pied un registre central ; définir les problèmes réels sur la base de données nationales ; analyser les différents taux de succès et compiler des statistiques ; exercer une surveillance à long terme au moyen d'études sur les aspects technique, médical et psychologique de la procréation médicalement assistée ; veiller à éviter l'exploitation et la mercantilisation dans le domaine de la procréation médicalement assistée ; encourager les recherches et études jugées nécessaires (par exemple, en vue de réévaluer la durée maximale du délai de congélation des gamètes et des embryons, de réduire le nombre de grossesses multiples et de mettre au point des techniques ne nécessitant pas la stimulation ovarienne, etc.) ; enfin, conseiller les autorités publiques en la matière. Afin de remplir ces fonctions, cet organisme devra pouvoir effectuer des inspections auprès des cliniques et des banques de gamètes et d'embryons et, en cas de non-respect des normes, obligations, restrictions et interdictions imposées, modifier, révoquer ou suspendre l'accréditation.

RECOMMANDATION

22. (1) Les autorités fédérales, provinciales et territoriales, de concert avec les spécialistes du milieu, devraient examiner la possibilité de mettre sur pied un organisme national de réglementation en matière de procréation médicalement assistée.

(2) Cet organisme national devrait avoir les attributions suivantes :

***a*) octroyer l'accréditation ;**

***b*) établir par règlement les différentes normes, obligations, restrictions et interdictions énumérées à la recommandation 21(1) et en assurer le respect ;**

***c*) mettre sur pied un registre central ;**

***d*) définir les problèmes sur la base de données nationales ;**

***e*) analyser les différents taux de succès et compiler des statistiques ;**

***f*) exercer une surveillance à long terme au moyen d'études sur les aspects technique, médical et psychologique de la procréation médicalement assistée ;**

g) veiller à empêcher l'exploitation et la mercantilisation dans le domaine de la procréation médicalement assistée ;

h) encourager les recherches et études jugées nécessaires ;

i) conseiller les autorités publiques en la matière ;

j) effectuer des inspections auprès des cliniques et des banques de gamètes et d'embryons accréditées et, au besoin, modifier, révoquer ou suspendre leur accréditation.

(3) Le gouvernement fédéral devrait prendre l'initiative d'organiser des rencontres dans le but de mettre sur pied un tel organisme.

Sommaire des recommandations

1. L'intervention éventuelle du législateur pour régir l'accès aux techniques de procréation médicalement assistée devrait respecter le droit à l'égalité. L'accès ne devrait être limité qu'en fonction du coût et de la rareté des ressources. Le cas échéant, la sélection ne pourrait reposer sur des motifs de discrimination illicites aux termes des législations fédérale et provinciales (la situation de famille, l'état matrimonial, l'orientation sexuelle, etc.).

2. Afin d'éviter de donner prise à l'eugénisme, la sélection des gamètes et des embryons en fonction de qualités particulières devrait être prohibée sauf lorsqu'elle a pour but d'éviter la transmission de maladies génétiques graves.

3. (1) La commercialisation du don de gamètes ou d'embryon devrait être interdite. Seul le remboursement des frais raisonnables engagés par le donneur devrait être autorisé.

(2) Il devrait être interdit aux banques de gamètes ou d'embryons d'exercer leurs activités dans un but lucratif. Toutefois, les banques devraient pouvoir se faire rembourser les frais raisonnables afférents à leurs activités et à leur fonctionnement.

4. Le contrat de maternité de substitution doit demeurer nul de nullité absolue. De plus, le fait d'agir comme intermédiaire rémunéré dans la conclusion d'un tel contrat devrait constituer une infraction criminelle.

5. (1) Avant la conception d'un embryon en vue d'un usage personnel futur, le ou les titulaires éventuels de l'autorité sur l'embryon devraient être tenus d'exprimer par écrit leur volonté quant au sort de l'embryon dans les cas suivants, notamment : décès du titulaire de l'autorité, abandon du projet parental, expiration du délai de congélation, divorce ou conflit entre les titulaires de l'autorité. Le titulaire de l'autorité sur un embryon devrait pouvoir, par écrit, modifier l'expression de sa volonté quant au sort de l'embryon tant que celui-ci n'a pas été utilisé aux fins prévues ; dans le cas où l'autorité serait partagée, toute modification devrait se faire d'un commun accord.

(2) L'autorité sur l'embryon issu des gamètes d'un couple devrait être exercée conjointement par les partenaires. L'autorité sur l'embryon issu des gamètes d'un seul des partenaires d'un couple et d'un donneur devrait être exercée exclusivement par le conjoint lié génétiquement à l'embryon. L'autorité sur l'embryon issu des gamètes de deux donneurs devrait être exercée par la banque ou la clinique qui en a la possession.

(3) L'utilisation de l'embryon devrait être limitée à l'implantation, à l'expérimentation et à la destruction ; à l'échéance du délai de congélation, toutefois, l'implantation devrait être prohibée.

(4) Le titulaire de l'autorité sur un embryon qui décide de donner celui-ci devrait être tenu, avant l'exécution du don, de faire une déclaration écrite exprimant son consentement au don et énumérant les conditions auxquelles celui-ci est assujetti quant à l'utilisation de l'embryon. Il devrait aussi pouvoir, au moyen d'une déclaration écrite, modifier ces conditions ou retirer son consentement en tout temps avant l'utilisation de l'embryon donné ; dans le cas où l'autorité serait partagée, toute modification devrait se faire d'un commun accord.

6. (1) L'autorité sur les gamètes devrait être attribuée au géniteur.

(2) La personne qui dépose ses gamètes en vue d'un usage personnel futur devrait être tenue, avant le dépôt, d'exprimer par écrit sa volonté quant au sort des gamètes dans les cas suivants, notamment : décès du titulaire de l'autorité, abandon du projet parental et expiration du délai de congélation. Le déposant devrait pouvoir, au moyen d'une déclaration écrite, modifier l'expression de sa volonté quant au sort de ses gamètes avant la conception d'embryons ou l'utilisation à laquelle les gamètes étaient destinés.

(3) La personne qui fait don de ses gamètes devrait être tenue avant l'exécution du don, de faire une déclaration écrite exprimant son consentement au don et énumérant les conditions auxquelles celui-ci est assujetti quant à l'utilisation des gamètes. Le donneur devrait pouvoir, par écrit, modifier ces conditions ou retirer son consentement en tout temps avant la conception d'embryons ou l'utilisation des gamètes donnés.

(4) L'utilisation des gamètes devrait être limitée à la fécondation, à l'expérimentation et à la destruction ; à l'échéance du délai de congélation, toutefois, la fécondation devrait être prohibée.

7. (1) Les lois provinciales sur la filiation devraient refléter la volonté des couples qui ont recours à la procréation médicalement assistée et déclarer irrecevables l'action en désaveu de paternité de la part du père qui a consenti au traitement et l'action en contestation de paternité de la part d'un tiers soutenant que l'enfant est issu de gamètes donnés.

(2) Aucun lien de filiation ne devrait pouvoir être établi entre le donneur et l'enfant.

(3) Les législations qui font toujours la distinction entre l'enfant légitime et l'enfant illégitime devraient reconnaître à l'enfant né grâce à la procréation médicalement assistée le statut d'enfant légitime.

8. Les lois provinciales sur les successions devraient être harmonisées afin d'établir que l'enfant né grâce à l'utilisation posthume de gamètes ou d'un embryon n'est pas successible à moins d'une mention expresse au testament du géniteur décédé.

9. Les cliniques offrant des services de procréation médicalement assistée devraient avoir l'obligation de présenter un rapport annuel écrit à un registre central, le contenu minimal du rapport et les modalités de présentation des données étant déterminés.

10. Des normes contraignantes et uniformes de sélection, de dépistage et de conservation à l'égard des donneurs, des gamètes et des embryons devraient être élaborées à l'échelle nationale.

11. Le sperme donné devrait être congelé et ne devrait être utilisé pour la fécondation qu'après que le donneur aura été soumis à des analyses adéquates pour le dépistage du virus du sida.

12. (1) L'embryon ne devrait pas pouvoir être congelé pendant plus de cinq ans. Les autorités fédérales devraient encourager les recherches sur les effets de la cryoconservation afin que cette limite puisse être réévaluée.

(2) Les gamètes ne devraient pas pouvoir être congelés pendant plus de dix ans. Les autorités fédérales devraient encourager les recherches sur les effets de la cryoconservation afin que cette limite puisse être réévaluée.

13. Le nombre de fois que les gamètes d'un même donneur peuvent être utilisés devrait être limité. Les études nécessaires devraient être encouragées afin que cette limite puisse être adéquatement fixée.

14. L'importation des gamètes et des embryons devrait être réservée aux banques accréditées. Les gamètes et les embryons importés devraient répondre aux normes canadiennes.

15. Il y aurait lieu de tout mettre en œuvre pour réduire les risques de grossesse multiple et favoriser la mise au point de techniques reposant sur le cycle normal d'ovulation. À cette fin, les autorités fédérales devraient encourager les études et la recherche visant à réduire le taux de grossesse multiple et à perfectionner les techniques ne nécessitant pas la stimulation ovarienne. En outre, les cliniques devraient avoir l'obligation d'enregistrer et de motiver le nombre d'embryons implantés au cours de chaque cycle de traitement.

16. Toute clinique qui offre des services en matière de procréation médicalement assistée devrait avoir l'obligation d'offrir aux personnes qui y ont recours, et ce, avant, pendant et après l'application d'un traitement, des services de consultation permettant à ces personnes d'obtenir auprès d'experts (médecins, psychologues, etc.) l'aide et l'information dont elles peuvent avoir besoin au sujet des problèmes particuliers de la procréation médicalement assistée.

17. (1) Les cliniques devraient être tenues de maintenir des dossiers (concernant le donneur ou la donneuse, la receveuse et l'enfant) permettant au médecin de relier le donneur ou la donneuse à la receveuse, tout en garantissant l'anonymat des parties.

(2) L'information recueillie devrait être limitée à ce qui est nécessaire à la poursuite des objectifs suivants : permettre l'accès à l'information médicale et génétique qui pourrait être nécessaire à l'efficacité des soins médicaux dispensés à l'enfant ; satisfaire les besoins psychologiques de l'enfant ; permettre une préparation adéquate des rapports cliniques et entreprendre des études sur les effets à long terme des différentes techniques de procréation médicalement assistée.

(3) Les cliniques devraient être garantes de la confidentialité de l'information qu'elles ont en leur possession.

18. À la demande des parents légaux ou de l'enfant, l'information non identifiante, notamment l'information d'ordre social (comme l'origine ethnique, la profession, le niveau d'instruction, l'appartenance religieuse et les centres d'intérêt du donneur ou de la donneuse), devrait pouvoir être divulguée. En revanche, l'information identifiante ne devrait pouvoir être divulguée que si le donneur ou la donneuse y consent.

19. L'identité du donneur ou de la donneuse qui omet de fournir des renseignements ou qui fournit de faux renseignements devrait pouvoir être révélée au ministère public en vue de poursuites pénales liées à cette réticence ou à cette déclaration mensongère.

20. Des études devraient être entreprises pour déterminer et mesurer les effets à long terme des techniques de procréation médicalement assistée sur les enfants qui en sont nés.

21. (1) Un système d'accréditation des cliniques et des banques de gamètes et d'embryons devrait être mis sur pied afin de réglementer, notamment, les questions suivantes :

***a*) les normes nationales de sélection et de conservation des gamètes et des embryons ;**

***b*) l'obligation de faire un rapport annuel à un registre central, de même que le contenu de ce rapport ;**

c) l'obligation de congeler le sperme donné et de l'utiliser seulement après que le donneur aura été soumis à des analyses adéquates pour le dépistage du virus du sida ;

d) l'obligation de motiver par écrit le nombre d'embryons implantés au cours de chaque cycle de traitement ;

e) l'obligation d'établir des services de consultation, ainsi que la composition et les fonctions de ces services de consultation ;

f) l'obligation de tenir des dossiers médicaux, de même que le contenu de ces dossiers ;

g) l'obligation de mettre sur pied un système permettant aux médecins de relier les donneurs et les donneuses aux receveuses tout en garantissant l'anonymat des parties ;

h) les obligations concernant l'accès à l'information identifiante et non identifiante ;

i) les restrictions concernant les formes d'utilisation permises et le délai de congélation des gamètes et des embryons, la fréquence d'utilisation des gamètes d'un même donneur et l'importation des gamètes et des embryons ;

j) les interdictions concernant la sélection et la commercialisation des gamètes et des embryons ;

k) les conditions relatives au don de gamètes et d'embryon, la notion d'autorité sur ceux-ci, la façon pour le titulaire de cette autorité d'exprimer sa volonté, ainsi que la portée et les modalités d'exercice de cette volonté.

(2) L'application des différentes techniques de procréation médicalement assistée devrait être réservée aux cliniques accréditées. D'autre part, la conservation et l'importation des gamètes et des embryons devraient être réservées aux banques de gamètes et d'embryons accréditées.

22. (1) Les autorités fédérales, provinciales et territoriales, de concert avec les spécialistes du milieu, devraient examiner la possibilité de mettre sur pied un organisme national de réglementation en matière de procréation médicalement assistée.

(2) Cet organisme national devrait avoir les attributions suivantes :

a) octroyer l'accréditation ;

b) établir par règlement les différentes normes, obligations, restrictions et interdictions énumérées à la recommandation 21(1) et en assurer le respect ;

c) mettre sur pied un registre central ;

d) définir les problèmes sur la base de données nationales ;

e) analyser les différents taux de succès et compiler des statistiques ;

f) exercer une surveillance à long terme au moyen d'études sur les aspects technique, médical et psychologique de la procréation médicalement assistée ;

g) veiller à empêcher l'exploitation et la mercantilisation dans le domaine de la procréation médicalement assistée ;

h) encourager les recherches et études jugées nécessaires ;

i) conseiller les autorités publiques en la matière ;

j) effectuer des inspections auprès des cliniques et des banques de gamètes et d'embryons accréditées et, au besoin, modifier, révoquer ou suspendre leur accréditation.

(3) Le gouvernement fédéral devrait prendre l'initiative d'organiser des rencontres dans le but de mettre sur pied un tel organisme.

ANNEXE A

Étude comparative des textes étrangers et canadiens traitant de la procréation médicalement assistée

Introduction[1]

La procréation médicalement assistée a fait l'objet de plusieurs études et rapports depuis un certain nombre d'années. Ces travaux ont mené, dans certains pays, à l'adoption de nouvelles dispositions législatives. Avant d'analyser les mesures qui ont été recommandées ou adoptées, il convient d'expliquer brièvement les démarches entreprises dans ce domaine à l'étranger, au Canada et au Québec[2].

En Australie, l'État de Victoria a été le premier à édicter une loi d'ensemble qui régit la procréation médicalement assistée et la maternité de substitution[3]. Le Commonwealth d'Australie et d'autres États ont aussi adopté des dispositions législatives[4], et tous les États australiens ont produit des rapports portant sur la procréation médicalement assistée[5]. Enfin, le Family Law Council a émis des recommandations au sujet des contrats de maternité de substitution[6] et le National Bioethics Consultative Committee s'est penché sur les problèmes liés à l'accès à l'information et à la maternité de substitution[7].

Au Danemark, le Conseil d'éthique national a abordé la question de la procréation médicalement assistée en 1990[8]. L'Espagne, s'inspirant des travaux du Conseil de

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1. Le lecteur trouvera à la fin de la présente annexe la liste des textes cités, regroupés et numérotés sous la rubrique des pays visés par nos recherches, *infra*, pp. 225-231.

2. Pour un aperçu de l'état du droit dans le monde, voir Jan STEPAN (dir.), *Recueil international de lois sur la procréation assistée*, Zurich, Schulthess Polygraphischer Verlag, 1990. Voir aussi EUROPE DE L'EST 1.

3. VICTORIA 1. Voir aussi VICTORIA 2.

4. COMMONWEALTH D'AUSTRALIE 1 ; AUSTRALIE-MÉRIDIONALE 1 et AUSTRALIE-MÉRIDIONALE 2 ; AUSTRALIE-OCCIDENTALE 1 ; NOUVELLE-GALLES DU SUD 1 ET NOUVELLE-GALLES DU SUD 2 ; QUEENSLAND 1 et QUEENSLAND 2 ; TASMANIE 1 ; TERRITOIRE DU NORD 1.

5. AUSTRALIE-MÉRIDIONALE 3 ; AUSTRALIE-OCCIDENTALE 2 ; NOUVELLE-CALLES DU SUD 3, NOUVELLE-GALLES DU SUD 4 et NOUVELLE-GALLES DU SUD 5 ; QUEENSLAND 3 ; VICTORIA 3 et VICTORIA 4.

6. AUSTRALIE 1.

7. COMMONWEALTH D'AUSTRALIE 2 et COMMONWEALTH D'AUSTRALIE 3. Le National Bioethics Consultative Committee a fait circuler, en octobre 1990, deux documents de consultation ; voir COMMONWEALTH D'AUSTRALIE 4 et COMMONWEALTH D'AUSTRALIE 5.

8. DANEMARK 1 ; ce rapport contient des recommandations au sujet de la protection du matériel humain et un projet de réglementation au sujet de l'insémination artificielle.

l'Europe[9], a adopté en 1988 une loi qui porte sur l'ensemble des techniques de procréation médicalement assistée. En 1989, le Conseil de l'Europe a autorisé la publication du rapport de son Comité ad hoc d'experts sur les progrès des sciences biomédicales (CAHBI) dans l'espoir de contribuer à l'harmonisation de la réglementation des États membres en matière de procréation médicalement assistée[10].

Aux États-Unis, une trentaine d'États ont adopté des dispositions législatives au sujet de la filiation des enfants nés à la suite d'une insémination artificielle hétérologue[11]. La Louisiane et la Pennsylvanie ont légiféré relativement à l'application clinique de la fécondation in vitro et l'Ohio a fait de même pour l'insémination hétérologue[12]. Le recours de plus en plus fréquent à la maternité de substitution a donné lieu à l'adoption de quelques lois[13] et à l'élaboration de plusieurs projets de loi[14]. Le New York Task Force on Life and the Law a publié des recommandations ainsi qu'un projet législatif à ce sujet en 1988[15]. L'American Fertility Society et son comité d'éthique ont émis des recommandations et des lignes directrices au sujet de la procréatique[16].

En France, le législateur n'a pas encore pris position sur ces questions, si ce n'est le Décret n° 88-327, où la procréation médicalement assistée est abordée sous l'angle du contrôle professionnel et de l'organisation hospitalière[17]. Cela dit, le Conseil d'État français a publié, en 1988, un rapport portant notamment sur la procréation médicalement assistée[18], et un avant-projet de loi traduisant ces recommandations a été déposé à l'Assemblée nationale[19].

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9. Voir ESPAGNE 1. Voir aussi ESPAGNE 2 et ESPAGNE 3, p. 241.

10. CONSEIL DE L'EUROPE 1. Cependant, le Comité n'a pas accordé au rapport le statut de recommandation officielle.

11. Voir, par exemple, LOUISIANE 1 ; MISSOURI 1, art. 210.824 ; NEW YORK 1, art. 1. Voir aussi ÉTATS-UNIS 5.

12. LOUISIANE 2, art. 121 à 133 ; PENNSYLVANIE 1, art. 3213 ; OHIO 1, art. 3111.30 à 3111.38. Voir aussi ÉTATS-UNIS 4, p. 249 ; LOUISIANE 4, art. 1062.1, et DELAWARE 1, art. 2801, au sujet des examens de dépistage à l'occasion de dons de gamètes ; ILLINOIS 1, par. 6(7), au sujet de la vente et de l'expérimentation sur le foetus ; TEXAS 1, art. 3A, au sujet du paiement des services par les compagnies d'assurances.

13. Voir, par exemple, ARKANSAS 1, art. 9-10-201 ; INDIANA 1, art. 31.8.1.2 à 31.8.2.1 ; KENTUCKY 1 ; LOUISIANE 3 ; MICHIGAN 1, art. 722.853 à 722.861 ; NEBRASKA 1 ; NEVADA 1, art. 127.287 et 127.288. Voir aussi ÉTATS-UNIS 3.

14. Voir NEW YORK 2, p. 99, n. 13. Voir aussi les projets de loi des États suivants : Alabama, Arizona, Connecticut, Delaware, Floride, Illinois, Iowa, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New Jersey, New York, Caroline du Nord, Oregon, Pennsylvanie, Rhode Island, Caroline du Sud, Texas, Wisconsin.

15. Voir le *Proposed Surrogate Parenting Act*, NEW YORK 2, p. A-1.

16. Seules les recommandations les plus récentes sont citées ; voir ÉTATS-UNIS 1 et ÉTATS-UNIS 2.

17. FRANCE 1.

18. FRANCE 6.

19. Voir FRANCE 5. Les dispositions législatives proposées modifient le *Code de la santé publique* (FRANCE 2), le *Code civil* (FRANCE 3) et le *Code pénal* (FRANCE 4). Les dispositions touchées sont citées à la suite de chaque article de l'avant-projet de loi.

En 1987, le Parlement norvégien a adopté une loi réglementant l'insémination artificielle et la fécondation in vitro[20], faisant suite aux recommandations formulées dans un projet législatif[21].

Au Royaume-Uni, le *Surrogacy Arrangements Act 1985*[22] porte sur la maternité de substitution et le *Human Fertilisation and Embryology Act 1990*[23] traite de l'ensemble des techniques de procréation médicalement assistée. Ce dernier fait suite aux recommandations d'une première étude importante menée sous la direction de Dame Mary Warnock[24], qui a conduit à l'élaboration d'un projet législatif, le « White Paper[25] ». De plus, des rapports annuels sont préparés par l'Interim Licensing Authority[26], organisme institué dans la foulée du rapport Warnock, qui n'a toutefois aucun pouvoir de contrainte.

En Suède, le Riksdag a adopté, en 1984 et en 1988 respectivement, une loi sur l'insémination artificielle[27] et une loi sur la fécondation in vitro[28]. En décembre 1990, le Parlement de l'ancienne République fédérale d'Allemagne a adopté une loi visant principalement la protection des embryons et l'utilisation inconsidérée de la procréation médicalement assistée[29].

Au Canada, les premières études publiées avaient une portée limitée à l'insémination artificielle. Le rapport de la Commission royale sur le droit de la famille et de l'enfance de la Colombie-Britannique a été publié en 1975[30] et celui du Comité consultatif sur le stockage et l'utilisation du sperme humain a été présenté au ministre de la Santé nationale et du Bien-être social en 1981[31].

La procréation médicalement assistée a été abordée globalement pour la première fois dans un document publié en 1985 par la Commission de réforme du droit de l'Ontario. Posant pour principe de base la non-intervention de l'État dans le domaine de la procréation, la Commission conclut toutefois à la nécessité d'une intervention législative en raison des implications de la procréatique pour les personnes autres que les futurs parents[32].

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20. Norvège 1.
21. Norvège 2.
22. Royaume-Uni 1.
23. Royaume-Uni 2.
24. Royaume-Uni 5.
25. Royaume-Uni 6.
26. Royaume-Uni 4 ; voir aussi Royaume-Uni 3.
27. Suède 1. Un règlement a également été adopté, voir Suède 3.
28. Suède 2 ; voir aussi Suède 4 et Suède 5, p. 387.
29. Voir Allemagne 1.
30. Colombie-Britannique 1.
31. Canada 3.
32. Ontario 1, pp. 119-120.

En mars 1987, la Commission de réforme du droit de la Saskatchewan a publié un court rapport et un projet législatif sur l'insémination artificielle, qui portent essentiellement sur la situation juridique de l'enfant et du donneur[33].

En juin 1989, la Section de la Colombie-Britannique de l'Association du Barreau canadien a rendu public un rapport sur la procréation médicalement assistée, dont les éléments principaux ont été entérinés comme politique fondamentale de l'Association en mars 1990[34].

Le Conseil consultatif canadien sur la situation de la femme a pour sa part opté, dans un document publié en février 1990, pour une approche différente de la procréation médicalement assistée en considérant avant tout la prévention de l'infertilité[35].

Enfin, la Société canadienne de fertilité et d'andrologie a émis des principes directeurs au sujet de l'insémination artificielle hétérologue en 1988[36] et, de concert avec la Société canadienne d'obstétriciens et de gynécologues, a récemment publié une analyse portant sur l'ensemble des techniques de procréation médicalement assistée[37].

Dans la province de Québec, le comité ad hoc du Barreau du Québec a formulé, en avril 1988, ses recommandations au sujet de la procréation médicalement assistée[38]. En 1988[39] et en 1989[40], le ministère de la Santé et des Services sociaux a publié deux rapports sur l'intégration de la procréatique au système de soins de santé du Québec et les orientations à prendre dans ce domaine. Depuis 1985, le Conseil du statut de la femme porte un intérêt particulier à la procréation médicalement assistée. La fusion de sept rapports et des communiqués recueillis lors d'un forum international organisé par le Conseil a permis la présentation d'un *Avis synthèse*[41] au Gouvernement du Québec en mai 1989. Enfin, en décembre 1990, le ministre de la Justice du Québec a présenté le projet de loi 125, *Code civil du Québec*, dans lequel cinq articles visent précisément la procréation médicalement assistée[42].

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33. SASKATCHEWAN 1.

34. CANADA 2.

35. CANADA 1. La procréation médicalement assistée y est assimilée à l'expérimentation.

36. CANADA 4.

37. CANADA 5.

38. QUÉBEC 1.

39. QUÉBEC 5. Dans une opinion dissidente du rapport de 1988, M[me] Francine McKenzie dénonce le laxisme qui prévaut dans la détermination de l'infertilité (un an de rapports sexuels sans contraceptifs) et dans la sélection des candidats (qui peuvent déjà avoir eu des enfants ou encore une stérilisation volontaire). Elle déplore l'acharnement dont peuvent être victimes les femmes, la banalisation des graves dangers sociaux inhérents à ces techniques et le triomphe de la technique sur l'humain, et elle s'oppose à l'expansion et au financement additionnel des cliniques de fertilité au Québec. Voir *Opinion synthèse de Madame McKenzie*, diffusée par communiqué de presse du Conseil du statut de la femme, le 18 avril 1988.

40. QUÉBEC 6.

41. QUÉBEC 4 ; voir aussi QUÉBEC 3.

42. QUÉBEC 7, art. 579 à 583.

Les démarches entreprises afin de saisir les implications de la procréation médicalement assistée sont importantes et nombreuses. La substance des mesures qui ont été adoptées ou recommandées est analysée dans trois grandes sections. La première traite des principes généraux, la seconde, de l'innocuité des techniques de procréation médicalement assistée, et la troisième, du contrôle médical et de l'encadrement de la procréatique.

I. Les principes généraux

Certains aspects de la procréation médicalement assistée appellent des choix sur les plans des principes et des valeurs. Ainsi en est-il de l'accès, de la commercialisation, de la maternité de substitution, de l'autorité sur les gamètes et les embryons, et de la filiation de l'enfant né grâce à la procréatique.

A. L'accès

L'accès à la procréation médicalement assistée est une question importante abordée dans la majorité des lois et rapports qui ont traité du sujet. Des conditions restrictives sont souvent proposées, le Conseil d'État français allant par exemple jusqu'à recommander d'infliger des sanctions pénales aux médecins qui y contreviendraient[43]. En revanche, quelques pays proposent de déférer la question au jugement du médecin[44]. Lorsqu'ils existent, les critères sont d'ordre personnel ou d'ordre médical.

1. Les critères d'ordre personnel

Parmi les critères d'accès d'ordre personnel qui sont considérés le plus fréquemment, citons l'état matrimonial, l'orientation sexuelle, la stabilité et le consentement du conjoint.

L'état matrimonial des candidats à la procréatique n'est pas un critère restrictif. Sauf en Norvège[45], les lois et rapports n'exigent pas que les couples soient unis par les liens du mariage.

La situation de couple et l'orientation sexuelle des partenaires sont des critères qui limitent l'accès d'une façon importante. Plusieurs pays recommandent en effet de n'accepter

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43. France 5, art. 10 — France 2, L. 675. Voir aussi Nouvelle-Galles du Sud 1, art. 9, Nouvelle-Galles du Sud 3, par. 6.14, rec. 8, et Nouvelle-Galles du Sud 4, rec. 9, pp. 66-67, qui prévoient que le médecin doit considérer certains facteurs au moment d'acquiescer à une demande, sous peine de se rendre coupable d'« inconduite professionnelle ».

44. Royaume-Uni 5, rec. 23, p. 132, et Royaume-Uni 6, par. 78 ; Canada 1, p. 29, et Canada 2, p. 22.

45. Norvège 1, art. 4. Signalons que l'avant-projet de loi permettait l'accès aux couples non mariés.

que les couples hétérosexuels[46]. Par contre, la Commission de réforme du droit de l'Ontario permettrait l'accès aux femmes seules[47] et les rapports du ministère de la Santé et des Services sociaux du Québec[48] et de l'American Fertility Society[49] proposent de leur permettre l'accès à l'insémination artificielle, quel que soit leur statut. La législation espagnole[50], la Société canadienne de fertilité et d'andrologie[51] et le Conseil d'éthique danois[52] acceptent les femmes seules ou formant un couple homosexuel. Enfin, un certain nombre de pays n'excluent pas les femmes seules[53]. Par ailleurs, la stabilité du couple[54] et le consentement du conjoint éventuel à l'intervention[55] sont quelquefois exigés.

2. Les critères d'ordre médical

Les critères d'accès d'ordre médical les plus fréquemment retenus sont l'expertise médicale et sociale, ainsi que l'infertilité ou la transmission d'affections génétiques.

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46. Voir, par exemple, AUSTRALIE-MÉRIDIONALE 2, art. 13(3), 13(4) et 13(7), et VICTORIA 1, art. 10 à 13A ; cette politique ne s'appliquerait toutefois pas à l'insémination artificielle. CONSEIL DE L'EUROPE 1, princ. 1 ; FRANCE 5, art. 10 et pp. 27-28 — FRANCE 2, L. 668-10 et L. 675 ; NORVÈGE 1, art. 4 ; SUÈDE 1, art. 2, SUÈDE 2, art. 2, et SUÈDE 5, p. 388 ; QUÉBEC 1, pp. 36-37, rec. 3, QUÉBEC 4, p. 13, rec. 2.1 et 3.1, et QUÉBEC 5, rec. 38 (pour FIV). Voir aussi tableau I, *infra*, pp. 212-213.

47. ONTARIO 1, rec. 5.

48. QUÉBEC 5, rec. 11, où l'on mentionne « les femmes seules, quel que soit leur statut. »

49. ÉTATS-UNIS 1, princ. IV.

50. ESPAGNE 1, art. 6, ESPAGNE 2, p. 237, et ESPAGNE 3, p. 242.

51. CANADA 4, p. 11 ; CANADA 5, p. 28, rec. 11 : [TRADUCTION] « La décision de restreindre l'accès au traitement ne devrait pas reposer sur des facteurs discriminatoires ni des stéréotypes. »

52. DANEMARK 1, p. 95, rec. 5.1, p. 124, et règl. 2.1, p. 131.

53. ÉTATS-UNIS 2, p. 24S ; ROYAUME-UNI 2, art. 13(6) et 28(4) ; COLOMBIE-BRITANNIQUE 1, rec. 3, 4, 5 et 14 : on favorise l'application des critères relatifs à l'adoption. NOUVELLE-GALLES DU SUD 1, art. 3(1), 7(2) et 9, NOUVELLE-GALLES DU SUD 3, pp. 43-44, par. 6.14 et rec. 7, et NOUVELLE-GALLES DU SUD 4, rec. 7, p. 65 (on exige toutefois que soient pris en considération les critères suivants : lorsque la femme est partie à un couple, l'infertilité du couple ou le risque de celui-ci de transmettre une affection génétique ; le bien-être et l'intérêt de l'enfant ; la stabilité du foyer ; la nécessité d'une consultation ; la santé physique et mentale, ainsi que l'âge du ou des futurs parents).

54. Voir, par exemple, NOUVELLE-GALLES DU SUD 1, art. 9, NOUVELLE-GALLES DU SUD 3, par. 6.14, rec. 7, et NOUVELLE-GALLES DU SUD 4, rec. 7 (la stabilité est considérée, mais n'est pas forcément décisive) ; ONTARIO 1, rec. 5, et CANADA 4, p. 11 ; QUÉBEC 1, p. 36. Voir aussi tableau II, *infra*, pp. 214-216. *Contra* : CANADA 1, p. 29.

55. VICTORIA 1, art. 10 à 13A (toutefois, cette exigence ne s'applique pas à l'insémination artificielle), et QUEENSLAND 3, rec. B(2) (vii) ; DANEMARK 1, règl. 1.1, p. 131 ; ESPAGNE 1, art. 6, ESPAGNE 2, p. 237, et ESPAGNE 3, p. 242 ; OHIO 1, art. 3111.34 et 3111.35, et ÉTATS-UNIS 1, princ. IV ; FRANCE 5, art. 10 et p. 28 ; FRANCE 2, L. 668-11 et L. 675 ; NORVÈGE 1, art. 4 ; ROYAUME-UNI 5, rec. 20, 21 et 26, pp. 132-133 ; SUÈDE 1, art. 2, SUÈDE 2, art. 2, SUÈDE 3 et SUÈDE 5, pp. 388-389 ; COLOMBIE-BRITANNIQUE 1, rec. 1, et CANADA 3, p. 29 et rec. 3.4. *Contra* : NOUVELLE-GALLES DU SUD 3, rec. 10, et NOUVELLE-GALLES DU SUD 4, rec. 8, pp. 65-66 ; CANADA 2, p. 15.

L'expertise médicale, qui peut comprendre des éléments psycho-sociaux, est quelquefois obligatoire[56] et l'appréciation du bien-être de l'enfant à naître est recommandée par quelques textes[57].

Il est souvent précisé que les personnes désirant avoir accès à la procréatique doivent être infertiles, stériles ou susceptibles de transmettre une maladie génétique[58]. Par exemple, certains États australiens exigent entre un et deux ans de traitements restés infructueux[59], et le rapport du Conseil du statut de la femme du Québec recommande de porter de un an à deux la période d'infécondité tendant à établir l'infertilité[60]. En ce qui a trait à la transmission d'affections génétiques, le Conseil d'État exige l'existence d'une forte probabilité de transmettre une affection incurable[61] et le Conseil de l'Europe, un problème génétique grave ou une maladie qui entraînerait la mort précoce ou un handicap grave, selon le jugement du médecin traitant[62].

Enfin, le choix du sexe de l'enfant à naître n'est habituellement permis que s'il existe un risque de transmission d'une maladie héréditaire grave liée au sexe[63] et un appariement « minimal » des caractéristiques du donneur et du conjoint de la femme inséminée est généralement conseillé[64].

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56. Victoria 1, art. 18 ; Nouvelle-Galles du Sud 1, art. 9, Nouvelle-Galles du Sud 3, par. 6.14, rec. 7, et Nouvelle-Galles du Sud 4, rec. 7, p. 65 (l'expertise médicale doit être considérée mais n'est pas concluante) ; Espagne 1, art. 2 et 6 ; Norvège 1, art. 5 ; Suède 1, art. 3 ; Colombie-Britannique 1, rec. 3, 4, 5 et 14. *Contra* : Québec 5, rec. 39 (les exigences ne sauraient être plus rigoureuses que celles qui s'appliquent à la procréation naturelle).

57. Nouvelle-Galles du Sud 1, art. 9, Nouvelle-Galles du Sud 3, par. 6.14, rec. 7, et Nouvelle-Galles du Sud 4, rec. 7, p. 65 ; Victoria 1 (voir art. 1(9) de l'ann. 3 du *Infertility (Medical Procedure) Regulations 1988*) ; Conseil de l'Europe 1, princ. 1 ; Royaume-Uni 2, par. 13(5) ; Suède 1, art. 3.

58. Australie-Méridionale 2, par. 13(3) et 13(7) ; Nouvelle-Galles du Sud 1, art. 9 ; Nouvelle-Galles du Sud 3, par. 6.14, rec. 7, et Nouvelle-Galles du Sud 4, rec. 7, p. 65 (chez les couples, cette règle doit être considérée mais n'est pas impérative) ; Queensland 3, rec. B(2) (i) et (ii) ; Victoria 1, art. 10 à 13A (cette exigence ne s'applique pas à l'insémination artificielle) ; Conseil de l'Europe 1, princ. 1 ; France 5, art. 10 et pp. 26-27 ; France 2, L. 668-10 et L. 675-1 ; Norvège 1, art. 8 et 12 ; Ontario 1, rec. 1 (cette exigence ne s'applique pas lorsqu'il s'agit d'une femme seule) ; Québec 1, p. 36 et rec. 3 ; Québec 4, p. 13 et rec. 2.1 ; Québec 5, rec. 11 et 38 (cette exigence s'applique aux couples qui ont recours à l'insémination artificielle hétérologue). Signalons que certains acceptent les techniques comme moyens de traiter l'infertilité, sans toutefois exiger l'infertilité dans leurs recommandations sur l'accès : voir, par exemple, Royaume-Uni 5, rec. 4 à 7 et 27, pp. 129, 130 et 133.

59. Victoria 1, art. 10 à 13A, Victoria 4, par. 3.6 et Queensland 3, rec. B(2) (ii).

60. Québec 4, p. 10 et rec. 1.5, 2.1 et 3.1. Voir aussi Québec 5, rec. 2, qui propose de réévaluer le délai d'un an.

61. France 5, art. 10 — France 2, L. 668-10.

62. Conseil de l'Europe 1, princ. 1.

63. États-Unis 2, p. 208 ; Royaume-Uni 5, par. 9.11, 9.12 et rec. 28, p. 133 ; Conseil de l'Europe 1, princ. 1 ; Allemagne 1, art. 3 ; Canada 5, pp. 46-47, rec. 28. Québec 4, p. 13 et rec. 2.6 ; Québec 5, rec. 12. *Contra* : Ontario 1, rec. 28.

64. Royaume-Uni 5, par. 4.21 ; Conseil de l'Europe 1, p. 20 ; États-Unis 1, princ. VIII, et Ohio 1, art. 3111.35 ; Canada 4, p. 8 ; Canada 5, p. 30, rec. 13 ; Québec 5, rec. 16.

B. La commercialisation

Les dispositions législatives et recommandations d'un grand nombre de pays condamnent la commercialisation en matière de procréation médicalement assistée. Cette mesure est formulée tantôt en termes généraux, tantôt de manière spécifique par référence soit à la gratuité des dons, soit à l'interdiction de la vente des gamètes et des embryons[65]. L'indemnisation est donc limitée au remboursement des frais raisonnables des donneurs (frais de déplacement, frais médicaux, perte de revenus)[66].

Lorsqu'il en est fait mention, les banques de gamètes et d'embryons à but lucratif sont généralement interdites[67]. Toutefois, le rapport de l'Ontario permettrait aux banques de gamètes dûment autorisées et réglementées d'exercer des activités de nature commerciale tout en étant assujetties à un contrôle public. Un tarif réglant le remboursement des frais et éventuellement les profits raisonnables serait établi et la vente serait limitée aux médecins, hôpitaux et autres banques licenciées[68].

C. La maternité de substitution

Les pays qui se sont prononcés sur la maternité de substitution ont choisi d'interdire, de décourager ou, dans de très rares cas, de réglementer cette pratique.

L'interdiction pure et simple de toute forme de maternité de substitution est relativement rare[69]. Les pays tentent plutôt de décourager cette pratique et de s'attaquer à son aspect

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65. Nouvelle-Galles du Sud 1, art. 12, et Victoria 1, art. 11 à 13A ; Danemark 1, rec. 11.1, p. 127 ; Espagne 1, art. 5 et 20 ; Conseil de l'Europe 1, p. 26 et princ. 9(1) et 9(2) ; Illinois 1, par. 6(7) ; Louisiane 2, art. 122 ; France 5, art. 10 — France 2, L. 668-6 et L. 668-13 ; Royaume-Uni 2, art. 12 et par. 41(8), et Royaume-Uni 4, princ. 15*d*) ; Suède 1, art. 7, et Suède 2, art. 4 ; Canada 1, p. 30 ; Québec 1, p. 23, et rec. 3 et 7 ; Québec 4, p. 13, rec. 2.4 ; Québec 5, rec. 20, 51 et 53 ; Québec 6, p. 61, et Québec 7, art. 25.

66. Nouvelle-Galles du Sud 1, art. 12 ; Nouvelle-Galles du Sud 3, par. 10.9, rec. 24 ; Queensland 3, rec. C(5) (vi) ; Victoria 1, art. 11 à 13A, et ann. 4, art. 3 ; Conseil de l'Europe 1, princ. 9(1) ; États-Unis 1, princ. VII(C) ; États-Unis 2, pp. 45S, 49S et 52S ; France 5, art. 10 — France 2, L. 668-6 (la perte de salaire est toutefois exclue) ; Royaume-Uni 5, par. 4.27, rec. 25, p. 132 ; Royaume-Uni 6, par. 63 ; Colombie-Britannique 1, p. 23 ; Ontario 1, rec. 15 ; Canada 3, p. 29, Canada 4, p. 10, et Canada 5, p. 41, rec. 25 ; Québec 1, p. 23, et Québec 5, rec. 21.

67. Voir, par exemple, Conseil de l'Europe 1, p. 26 et princ. 9(2) (le remboursement de certains frais est cependant admis : collecte, prélèvement, conservation, implantation et services médicaux) ; France 5, art. 10 — France 2, L. 668-13 ; Québec 5, rec. 53, et Québec 6, p. 61. Voir aussi les interdictions générales citées aux notes précédentes.

68. Ontario 1, rec. 17 et 18 : on suggère un mode de fonctionnement semblable à celui de la Société canadienne de la Croix-Rouge. Voir aussi Canada 5, p. 39, rec. 23 : on propose, à défaut de financement public adéquat, la mise sur pied de banques à but lucratif.

69. Allemagne 1, par. 1(1)7 ; France 5, art. 16 — France 4, art. 353 ; Queensland 2, art. 2 et 3 ; Québec 1, pp. 27-30 et rec. 17. Voir aussi Danemark 1, p. 100, où l'on s'oppose à la maternité de substitution sans toutefois proposer de changements à la législation criminelle en ce domaine. Pour ce qui est du droit américain, voir États-Unis 3.

commercial. Dans cette optique, ils prohibent l'activité (même à titre gratuit) des agences ou autres intermédiaires[70] , et interdisent toute forme de publicité relative à la maternité de substitution[71] ou, encore, le fait de payer ou de recevoir une rétribution, pécuniaire ou autre, reliée à un contrat de maternité de substitution[72].

Par ailleurs, d'autres pays n'interdisent pas la maternité de substitution, permettent les contrats à titre gratuit et se sont abstenus de légiférer à l'égard des ententes privées. Dans ce contexte, l'activité des intermédiaires non rémunérés n'est pas prohibée[73]. Un remboursement limité aux frais est possible[74]. Dans certains cas, les parties elles-mêmes ne peuvent être poursuivies[75]. Enfin, la mesure recommandée le plus souvent consiste à rendre le contrat de maternité de substitution inexécutoire en justice ou à le déclarer nul et non avenu[76].

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70. AUSTRALIE-MÉRIDIONALE 1, art. 10*h* ; NOUVELLE-GALLES DU SUD 5, rec. 5 et 6, pp. 44-53 ; VICTORIA 1, art. 30 ; AUSTRALIE 1, rec. 17 et par. 6.6.16 ; CONSEIL DE L'EUROPE 1, princ. 15(1), 15(3) et 15(4) ; MICHIGAN 1, art. 722.859, division 9 ; NEW YORK 2, p. 126, art. 3 du *Proposed Surrogate Parenting Act* ; FRANCE 5, art. 16 et pp. 31-32 — FRANCE 4, art. 353.1 ; ROYAUME-UNI 1, art. 2, ROYAUME-UNI 5, par. 8.18 et rec. 57, p. 137, et ROYAUME-UNI 6, par. 73 ; QUÉBEC 1, rec. 18 et 20, QUÉBEC 4, p. 21 et rec. 4.1, QUÉBEC 5, rec. 56 et 57, et QUÉBEC 6, p. 60.

71. Voir, par exemple, AUSTRALIE-MÉRIDIONALE 1, art. 10*h* ; NOUVELLE-GALLES DU SUD 5, rec. 4, pp. 43-44 ; QUEENSLAND 2, art. 3 ; VICTORIA 1, art. 30 ; AUSTRALIE 1, par. 6.6.16 ; CONSEIL DE L'EUROPE 1, princ. 15(3) ; ROYAUME-UNI 1, par. 3(1) ; QUÉBEC 4, p. 21 et rec. 4.2, QUÉBEC 5, rec. 56, et QUÉBEC 6, p. 60.

72. AUSTRALIE-MÉRIDIONALE 1, art. 10*g* et 10*h* (pour intermédiaires) ; NOUVELLE-GALLES DU SUD 5, rec. 3 et pp. 40-43 ; QUEENSLAND 2, art. 3 ; VICTORIA 1, art. 30 ; AUSTRALIE 1, rec. 17 et par. 6.6.15 ; CONSEIL DE L'EUROPE 1, princ. 15(4) ; MICHIGAN 1, art. 722.859, division 9, et NEW YORK 2, p. 126, art. 3 du *Proposed Surrogate Parenting Act* (cette règle ne s'applique pas au remboursement des frais d'adoption, médicaux et juridiques, à l'exclusion, toutefois, de la perte de salaire) ; ROYAUME-UNI 1, par. 2(3) (exclut le paiement à la femme porteuse) ; CANADA 1, p. 30, et CANADA 2, pp. 26-33 et rec. 9*d*). *Contra* : NEVADA 1, art. 127.287. Voir aussi ÉTATS-UNIS 3.

73. AUSTRALIE-MÉRIDIONALE 1, art. 10*h* ; VICTORIA 1, art. 30 ; MICHIGAN 1, art. 722.859 ; NEW YORK 2, p. 126, art. 3 du *Proposed Surrogate Parenting Act* (le médecin peut être rémunéré pour ses services) ; ÉTATS-UNIS 2, p. 67S ; ROYAUME-UNI 1, art. 2.

74. MICHIGAN 1, art. 722.853. division 3*a* ; NEW YORK 2, p. 126, art. 3 du *Proposed Surrogate Parenting Act* (la perte de salaire est toutefois exclue) ; ÉTATS-UNIS 2, p. 67S (on accepte la possibilité d'un paiement supérieur) ; ROYAUME-UNI 1, par. 2(3) (est exclu le paiement fait à la femme porteuse) ; ONTARIO 1, pp. 253-255, rec. 51 ; CANADA 5, p. 42, rec. 26.

75. Voir aussi ROYAUME-UNI 5, par. 8.19, et ROYAUME-UNI 6, par. 73 ; QUÉBEC 5, rec. 57 ; ALLEMAGNE 1, art. 1 : [TRADUCTION] « Est passible d'une peine d'emprisonnement de trois ans ou d'une amende quiconque : [. . .] (vii) tente de pratiquer une insémination artificielle ou un transfert d'embryon humain sur une femme disposée à renoncer définitivement à l'enfant à la naissance de celui-ci (femme porteuse). » Toutefois, le par. (3) soustrait la femme porteuse et les parents sociaux à l'application de cette disposition : [TRADUCTION] « Pour l'application de l'alinéa 1(vii), la femme porteuse, de même que la personne qui désire assumer la responsabilité de l'enfant, ne peut être punie ». Des poursuites sont toutefois possibles, dans certains pays, en cas de paiement ou de publicité ; voir tableau IV, *infra*, pp. 221-224.

76. AUSTRALIE-MÉRIDIONALE 1, art. 10*g* ; NOUVELLE-GALLES DU SUD 5, rec. 8, pp. 55-60 ; QUEENSLAND 2, art. 4 ; VICTORIA 1, par. 30(3) ; AUSTRALIE 1, rec. 17 et par. 6.6.15 ; COMMONWEALTH D'AUSTRALIE 3, p. 36 ; ESPAGNE 1, art. 10, ESPAGNE 2, p. 237, et ESPAGNE 3, p. 242 ; CONSEIL DE L'EUROPE 1, princ. 15(2) ; INDIANA 1, art. 31.8.2.1 ; MICHIGAN 1, art. 722.855, division 5 ; NEW YORK 2, art. 2 du *Proposed Surrogate Parenting Act* ; FRANCE 5, art. 11 — FRANCE 3, art. 342-12 ; ROYAUME-UNI 2, par. 36(1) (qui modifie le *Surrogacy Arrangements Act 1985*), ROYAUME-UNI 5, par. 8.19, rec. 58, p. 137, et ROYAUME-UNI 6, par. 73 ; CANADA 2, rec. 9*b*) (le contrat de maternité de substitution serait valide mais inopposable à la femme porteuse) ; QUÉBEC 1, rec. 18, et QUÉBEC 7, art. 582. Voir aussi ÉTATS-UNIS 3.

Aux États-Unis, l'American Fertility Society permet la maternité de substitution pour des raisons strictement médicales, au même titre que toute autre forme d'expérimentation clinique qui doit être étudiée à fond. Les parties seraient informées des risques psychologiques qu'elle peut comporter[77].

La Commission de réforme du droit de l'Ontario recommande de légaliser la maternité de substitution mais de la réglementer. Un rôle majeur est dévolu au tribunal : celui-ci doit approuver l'entente avant la conception, mais après détermination de l'aptitude des requérants à devenir parents, de leur stabilité individuelle et de celle de leur couple, et de la nécessité, sur le plan médical, du recours à cette technique. Le juge doit en outre porter un jugement sur la future femme porteuse : santé physique et mentale, situation familiale et opinion du conjoint, effets sur les autres enfants. Il doit s'assurer que des analyses sanguines sont effectuées afin de prévenir toute contestation ultérieure au sujet de la filiation de l'enfant, approuver tout paiement éventuel et s'assurer qu'il y a entente sur les sujets suivants : assurances, décès ou séparation des requérants, conduite et alimentation avant et pendant la grossesse, examens diagnostics, modalités de remise de l'enfant et rapports futurs entre la femme porteuse et l'enfant[78].

D. L'autorité sur les gamètes et les embryons

Les recommandations à ce sujet varient sensiblement d'un pays à l'autre. Par exemple, certains reconnaissent au donneur un droit de propriété sur ses gamètes[79], tandis que d'autres appliquent à l'embryon le régime juridique régissant les personnes[80]. La Louisiane accorde même à l'embryon in vitro la personnalité juridique jusqu'au moment de son implantation[81]. L'étendue de l'autorité des donneurs sur les gamètes et les embryons est examinée ici sous deux angles différents : l'exercice de cette autorité et la fécondation posthume.

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77. ÉTATS-UNIS 2, p. 67S. Au même effet, voir CANADA 5, p. 27, rec. 10 :

    [TRADUCTION]
    Les Sociétés recommandent ce qui suit :

    1. La maternité de substitution devrait être permise lorsqu'elle est justifiée par des raisons médicales ;

    2. Des recherches de longue haleine devraient être entreprises afin d'apprécier soigneusement les effets de la maternité de substitution sur tous les intéressés.

    Voir aussi CONSEIL DE L'EUROPE 1, princ. 11 et 15(4) (le Conseil laisse aux États membres le choix de permettre ou d'interdire la maternité de substitution).

78. ONTARIO 1, rec. 34 à 66 ; l'audience doit avoir lieu à huis clos et l'activité des intermédiaires serait réglementée. Signalons par ailleurs que l'un des commissaires s'est opposé au principe même de la légalisation de la maternité de substitution : *id.*, pp. 287-291. COMMONWEALTH D'AUSTRALIE 3, p. 36 : on recommande que la maternité de substitution ne soit pas totalement interdite mais que son application soit strictement réglementée.

79. NOUVELLE-GALLES DU SUD 3, par. 10.14, et NOUVELLE-GALLES DU SUD 4, rec. 23*i*), p. 86. Voir cependant ROYAUME-UNI 5, par. 10.11 et 11.17, rec. 41 et 61, pp. 135 et 137 (on propose d'offrir une protection légale à l'embryon, sans toutefois qu'il n'existe un droit de propriété sur l'embryon humain), et CANADA 2, rec. 10(*d*) (les tissus humains ne doivent pas être traités comme des marchandises).

80. QUÉBEC 1, p. 15 ; FRANCE 5, p. 34.

81. LOUISIANE 2, art. 123-126 : l'embryon a la personnalité juridique, peut poursuivre ou être poursuivi par l'entremise d'un curateur.

1. L'exercice de l'autorité

L'autorité sur les produits humains s'exerce généralement au moyen d'un formulaire de consentement décrivant les façons dont les gamètes et les embryons pourront être utilisés.

a) Le consentement

Le consentement au don ou à la conservation des gamètes et des embryons doit généralement être écrit et quelquefois signé par les deux conjoints[82]. Certains pays exigent que le formulaire de consentement signé au moment du don stipule dans quelles conditions les gamètes peuvent être utilisés, conservés ou détruits[83], et indique, aux fins de conservation, les voeux respectifs des partenaires en cas de décès, de mésentente et de divorce[84].

On trouve aussi des dispositions particulières régissant le sort des gamètes. Au décès du géniteur, à l'expiration du délai de conservation ou si le géniteur est introuvable, trois solutions sont possibles : les gamètes sont détruits[85] ; les droits des géniteurs sont dévolus à l'organisme qui conserve les gamètes, compte tenu des désirs exprimés par le géniteur[86] ; les gamètes sont utilisés ou détruits à la discrétion de l'organisme dépositaire[87].

Quant à l'embryon en état de conservation, au décès du couple, à l'expiration du délai de conservation, en cas de mésentente ou si le couple est introuvable, les trois mêmes solutions sont possibles : l'embryon est détruit[88] ; l'autorité des géniteurs est dévolue à l'organisme dépositaire, qui doit toutefois tenir compte des désirs du couple[89] ; l'embryon

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82. Queensland 3, rec. B(3) (xix), Victoria 1, art. 9 à 13A ; Danemark 1, rec. 6.1 et 7.1, pp. 124-125, règl. 3.1, p. 132 ; Conseil de l'Europe 1, p. 22 et princ. 4 et 9(3) ; États-Unis 2, p. 60S, et États-Unis 1, princ. VII(C) ; France 5, art. 10 — France 2, L. 668-5 ; Royaume-Uni 4, princ. 15 et 16 et Royaume-Uni 6, par. 55 ; Colombie-Britannique 1, rec. 9 et 10 ; Canada 3, p. 29, rec. 3.4 ; Ontario 1, rec. 12 et Canada 4, pp. 10-13.

83. Australie-Méridionale 2, art. 10(3) ; Victoria 1, art. 11 à 13A, et Nouvelle-Galles du Sud 3, par. 10.18, rec. 26 ; Espagne 1, art. 5 ; France 5, art. 10 — France 2, L. 668-11 et L. 668-12 ; Royaume-Uni 2, ann. 3, art. 2, 3, 6 et 8, Royaume-Uni 4, princ. 15*d*), et Royaume-Uni 6, par. 55 ; Ontario 1, rec. 13 et 14 ; Canada 5, p. 31, rec. 14.

84. États-Unis 2, p. 60S ; Royaume-Uni 2, ann. 3, art. 2 et 3, et Royaume-Uni 6, par. 60 ; Canada 5, p. 40, rec. 24 ; Québec 5, rec. 47 et 48.

85. Danemark 1, p. 97 et rec. 6.1, p. 124 ; Conseil de l'Europe 1, pp. 24-25 et princ.7 ; France 5, art. 10 — France 2, L. 668-3 ; Royaume-Uni 2, art. 14, et Royaume-Uni 6, par. 57 ; Québec 1, rec. 9. *Contra* : Québec 5, p. 49, rec. 35.

86. Nouvelle-Galles du Sud 3, par. 10.18 et rec. 26 ; Royaume-Uni 6, par. 57.

87. Royaume-Uni 5, par. 10.8, rec. 59, p. 137.

88. Nouvelle-Galles du Sud 4, rec. 2 et 22 ; Danemark 1, rec. 6.1, p. 124 ; Conseil de l'Europe 1, pp. 25-26 et princ. 8 ; France 5, art. 10 — France 2, L. 670 ; Royaume-Uni 2, art. 14 et Royaume-Uni 6, par. 57, 58 et 60 ; Ontario 1, rec. 32 ; Québec 1, p. 34.

89. Royaume-Uni 6, par. 57, 58 et 60. Voir aussi Nouvelle-Galles du Sud 4, par. 5.51, qui prévoit le statu quo jusqu'à la fin du délai de conservation en cas de mésentente.

est utilisé ou détruit à la discrétion de l'organisme dépositaire[90]. Si un seul partenaire du couple décède, l'embryon est détruit[91] ou les droits dont il est l'objet sont dévolus au partenaire survivant[92].

Selon le rapport de la Commission de réforme du droit de l'Ontario, l'embryon conçu grâce aux gamètes d'un donneur et d'un des partenaires serait soumis à l'autorité exclusive de ce dernier. L'autorité sur l'embryon issu des gamètes de deux donneurs appartiendrait à l'organisme qui en a la possession tant qu'il n'est pas implanté chez la femme pour qui il a été conçu[93].

En général, un consentement explicite est requis pour toute forme d'utilisation des gamètes et des embryons, et la volonté exprimée par les géniteurs doit être respectée[94]. Les conditions auxquelles est assujetti un don de gamètes peuvent aussi s'appliquer à l'embryon issu de ces gamètes[95], mais un don inconditionnel prive le donneur de tout droit à l'égard de l'utilisation de ses gamètes ou de l'embryon qui en est issu[96].

Le Conseil de l'Europe permet d'assortir le don de conditions raisonnables et non-discriminatoires[97]. Pour sa part, le Barreau du Québec s'oppose au don assorti de conditions visant le couple ou la receveuse[98]. Le don fait à une personne déterminée est quelquefois interdit[99], mais d'autres autorités ne s'y opposent pas pour peu que les précautions habituelles aient été prises[100]. Le consentement peut généralement être

90. Nouvelle-Galles du Sud 4, rec. 2 et 26 ; Royaume-Uni 5, par. 10.10, rec. 31, p. 133 ; Ontario 1, rec. 27(1). Voir, cependant, Québec 5, rec. 48, selon laquelle un comité d'éthique jugerait du sort des embryons si le couple est introuvable, ou s'il y a désaccord ou abandon du projet parental.

91. Danemark 1, p. 101, rec. 6.1, p. 124 ; France 5, art. 10 — France 2, L. 670 ; Royaume-Uni 6, par. 60.

92. Nouvelle-Galles du Sud 4, rec. 2 et 25 ; Royaume-Uni 5, par. 10.12, rec. 32, p. 133, et Royaume-Uni 6, par. 59 ; Ontario 1, rec. 27(1).

93. Ontario 1, rec. 27(1) et (2).

94. Nouvelle-Galles du Sud 1, art. 13, Nouvelle-Galles du Sud 4, rec. 2, 23 et 24 ; Victoria 1, art. 9 à 13A ; Danemark 1, rec. 4.1, p. 123, règl. 4.2, p. 132 ; Espagne 1, art. 13 à 15 ; Conseil de l'Europe 1, p. 26 et princ. 8(3) et 17(2) ; États-Unis 2, pp. 36S et 60S ; Louisiane 2, art. 126 et 130 ; France 5, art. 10 — France 2, L. 668-12, L. 668-13, L. 669, L. 671, L. 672 et L. 676-2 ; Royaume-Uni 2, ann. 3, art. 5, Royaume-Uni 4, princ. 5 et 6, et Royaume-Uni 5, par. 11.24, rec. 13 et 14, pp. 130-131, Royaume-Uni 6, par. 51 et 56 ; Allemagne 1, art. 4 ; Ontario 1, rec. 12 ; Canada 2, rec. 10*b*) ; Québec 1, rec. 23, 25 et 27, et Québec 5, rec. 45, 47 et 50.

95. Conseil de l'Europe 1, princ. 17(2) ; Royaume-Uni 2, ann. 3, art. 2 et 6 ; Ontario 1, rec. 13, 26 et 27(2).

96. Nouvelle-Galles du Sud 3, par. 10.13, et Nouvelle-Galles du Sud 4, rec. 23 ; Ontario 1, rec. 27(2).

97. Conseil de l'Europe 1, p. 26 et princ. 9(3) ; par exemple, utilisation des gamètes à l'extérieur de la région où ils ont été donnés.

98. Québec 1, p. 24.

99. Royaume-Uni 4, princ. 13(*j*) : on déconseille l'utilisation de gamètes provenant de personnes connues ou de proches parents ; France 5, art. 10 et p. 25 — France 2, L. 668-7 ; Québec 1, p. 24.

100. Nouvelle-Galles du Sud 3, par. 8.4 ; Victoria 1, art. 16 ; États-Unis 2, pp. 49S-50S et 52S ; Royaume-Uni 5, par. 6.7 ; voir aussi Québec 5, p. 43.

modifié ou retiré avant l'utilisation du produit du don[101], encore que certains pays le considèrent irrévocable[102].

b) L'utilisation des gamètes

Le don de gamètes est souvent assujetti à des restrictions. Les législations suédoise et norvégienne interdisent le don d'ovule et de sperme pour la fécondation in vitro[103]. Le Barreau du Québec propose de permettre les dons de gamètes si ceux-ci sont utilisés à des fins thérapeutiques[104]. Le Conseil de l'Europe précise que, dans le cadre de la fécondation in vitro, il est préférable d'utiliser les gamètes du couple[105]. Au Québec, un rapport propose d'interdire le don d'ovule[106] tandis qu'un autre suggère de l'assujettir à des conditions restrictives : l'ovule ne pourrait être prélevé dans le seul but d'être donné et devrait provenir d'une femme qui subit des traitements d'infertilité et qui en a suffisamment pour ses propres besoins[107]. Enfin, l'utilisation du sperme de plusieurs donneurs, lors d'un même cycle, pour l'insémination artificielle est souvent interdite ou, à tout le moins, déconseillée[108].

L'utilisation des gamètes de mineurs est généralement déconseillée[109]. Toutefois, l'Ontario propose de l'autoriser, mais ne permettrait le don d'ovule que s'il y a consentement éclairé et si l'ovule est donné à l'occasion d'une autre opération, telle une hystérectomie[110]. L'expérimentation sur les gamètes ne soulève généralement pas de problèmes[111].

c) L'utilisation de l'embryon

Certains pays interdisent le don d'embryon[112], tandis que d'autres l'assujettissent à

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101. Victoria 1, art. 11 à 13A et art. 15 ; Conseil de l'Europe 1, princ. 9(3) ; Royaume-Uni 2, ann. 3, art. 4, Royaume-Uni 4, princ. 15*b*), et Royaume-Uni 6, par. 57 ; Ontario 1, rec. 13 et 14.

102. Australie-Méridionale 3, p. 25 ; Danemark 1, p. 99 ; voir aussi Espagne 1, art. 5, où la stérilité ultérieure du donneur est le seul motif permettant à celui-ci de revenir sur son consentement, à charge pour lui d'indemniser la receveuse.

103. Suède 2, art. 2 ; Norvège 1, art. 12.

104. Québec 1, p. 23.

105. Conseil de l'Europe 1, p. 27 et princ. 11(1). Voir aussi Danemark 1, rec. 7.1*a* et 7.1*b*, p. 125 (position minoritaire).

106. Québec 4, p. 17, rec. 3.1.

107. Québec 5, rec. 50 et 51 ; voir également Allemagne 1, al. 1(1)i et ii.

108. Nouvelle-Galles du Sud 3, par. 9.24, rec. 22 et 23 ; Victoria 1, art. 26 ; Espagne 1, art. 20 ; Suède 3 ; Canada 3, rec. 3.5 ; Québec 4, rec. 2.8, Québec 5, rec. 26, et Québec 6, p. 60.

109. Queensland 3, rec. B(3) (iii) ; Victoria 1, art. 25 (à moins que le mineur ne soit marié) ; Espagne 1, art. 5.

110. Ontario 1, rec. 10 et 11.

111. Voir, par exemple, Espagne 1, art. 14, et Espagne 2, p. 238 (les gamètes soumis à l'expérimentation ne pourraient toutefois être utilisés aux fins de procréation) ; voir également Canada 5, pp. 43-45, rec. 27.

112. Norvège 1, art. 3 et 12, et Suède 2, art. 2. Voir aussi Danemark 1, rec. 7.1*a*, p. 125 (position minoritaire) ; Allemagne 1, art. 1(1)v, ne permet pas la création d'embryons surnuméraires.

des conditions précises : les donneurs doivent avoir réalisé ou abandonné leur projet parental et le couple receveur doit être en traitement[113] ; le don doit être restreint à des circonstances exceptionnelles, notamment en vue d'éviter que l'embryon soit détruit ou qu'il soit soumis à l'expérimentation[114], à moins que le consentement au don n'ait été donné avant la fécondation[115].

Le but de la création d'embryons est souvent restreint à la procréation[116] ou au traitement du couple ; l'embryon ne peut donc être conçu dans le seul but d'être donné[117]. La Commission de réforme du droit de l'Ontario propose de permettre l'implantation d'embryons issus de différents donneurs chez une même personne[118], mais certains pays s'y opposent[119].

En ce qui a trait à la recherche sur les embryons, bien que certains pays l'interdisent[120], la majorité préfèrent la réglementer. Plusieurs formes d'expérimentation sont interdites (clonage, croisement de gamètes humains avec ceux d'autres espèces, manipulations génétiques, parthénogénèse, ectogénèse[121]) et la recherche doit souvent être approuvée ou autorisée par une autorité quelconque[122]. L'expérimentation sur l'embryon in vitro n'est généralement permise que si elle a un but thérapeutique ou préventif[123], sur des embryons qui n'ont pas les qualités requises pour se développer[124], ou si le but recherché ne peut être atteint autrement[125].

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113. Louisiane 2, art. 130 ; France 5, art. 10 — France 2, L. 671 et L. 676 ; Québec 1, pp. 32-33.

114. Conseil de l'Europe 1, pp. 27-28 et princ. 11 et 12 ; Québec 1, rec. 24, p. 39.

115. Victoria 1, art. 13. Des services de consultation doivent avoir été fournis au couple au moment où il a consenti à faire le don. Le Ministre peut également autoriser le don si les géniteurs sont décédés ou introuvables (art. 14).

116. Espagne 1, art. 3 et 20, et Espagne 3, p. 243 ; Louisiane 2, art. 122 ; Allemagne 1, art. 1 et 2 ; Québec 6, p. 61. Voir aussi Danemark 1, rec. 7.1c, p. 125 (position minoritaire).

117. Conseil de l'Europe 1, p. 25 et princ. 8(1) ; France 5, art. 10 — France 2, L. 669 ; Québec 1, p. 32, rec. 22 et 26, et Québec 5, rec. 49.

118. Ontario 1, rec. 26.

119. Victoria 1, art. 13 ; Espagne 1, art. 20.

120. Danemark 1, rec. 3.1, p. 129 (position minoritaire) ; Norvège 1, art. 3 et 14 ; Royaume-Uni 5, par. 11.18 ; Québec 4, p. 13, rec. 6.4 : le Conseil du statut de la femme du Québec recommande l'imposition d'un moratoire à ce chapitre.

121. Voir, par exemple, Nouvelle-Galles du Sud 4, rec. 13, p. 71, et Victoria 1, art. 6 ; Danemark 1, rec. 9.1 et 10.1, pp. 125-126 ; Espagne 1, art. 14, 15 et 20 ; Conseil de l'Europe 1, princ. 20 et 21 ; France 5, art. 10 — France 2, L. 673 ; Royaume-Uni 2, art. 3 et ann. 2, art. 3, Royaume-Uni 4, préambule et princ. 10, Royaume-Uni 5, par. 12.3, rec. 15, 46 et 47, pp. 131, 135-136, Royaume-Uni 6, par. 37, 39, 41 et 42 ; Allemagne 1, art. 5 à 7 ; Canada 2, rec. 10*f*).

122. Voir, par exemple, Australie-Méridionale 2, art. 14 ; Nouvelle-Galles du Sud 4, rec. 17 à 19 ; Victoria 1, art. 6 et 29 ; Danemark 1, rec. 4.1, p. 123, et rec. 12.1 à 13.2, p. 127 ; Espagne 1, art. 14 et 15, et Espagne 2, p. 238 ; Conseil de l'Europe 1, princ. 17(2) ; France 5, art. 10 — France 2, L. 673 ; Royaume-Uni 2, art. 11 et ann. 2, art. 3, Royaume-Uni 4, princ. 5, et Royaume-Uni 5, par. 11.18 et 12.16, rec. 11, 42 et 48, pp. 130, 135-136 ; Ontario 1, rec. 29, et Canada 2, rec. 10*e*) ; Canada 5, pp. 43-45, rec. 27 ; Québec 6, p. 61.

123. Voir, par exemple, Australie-Méridionale 2, par. 14(2) ; Victoria 1, art. 9A ; Danemark 1, rec. 4.1, p. 123 ; Espagne 1, art. 12 et 16 ; Conseil de l'Europe 1, princ. 17(1) ; Illinois 1, par. 6(7) ; Royaume-Uni 2, ann. 2, art. 3, et Royaume-Uni 4, princ. 3 ; Québec 1, pp. 33-34, rec. 27.

124. Voir, par exemple, Espagne 1, art. 15, et Espagne 2, p. 238.

125. Voir, par exemple, Danemark 1, rec. 4.1, p. 123 ; Espagne 1, art. 15 et 16 ; Conseil de l'Europe 1, princ. 17(2) ; Royaume-Uni 4, princ. 2.

Quelques pays interdisent l'expérimentation sur l'embryon in vivo[126] et précisent que l'embryon ayant fait l'objet de recherches in vitro ne peut être implanté dans l'utérus d'une femme, sauf lorsqu'il s'agit d'améliorer ses chances de grossesse[127], ou que l'expérimentation était de nature thérapeutique[128]. Enfin, la création ou le recueil d'embryons aux seules fins de recherche sont souvent interdits[129].

2. L'utilisation posthume des gamètes et des embryons

L'utilisation posthume des gamètes ou des embryons issus d'un partenaire décédé est permise dans certains pays[130]. Au Royaume-Uni, sauf disposition testamentaire expresse, l'intervention doit être pratiquée avant le décès pour qu'il y ait un lien de filiation entre l'enfant et le géniteur décédé[131]. En Espagne, le lien de filiation n'est possible que si la fécondation a lieu dans les six mois qui suivent le décès et que le père ait reconnu l'enfant à naître dans un testament ou autre disposition notariée[132]. En Australie, l'enfant conçu après le décès du géniteur par insémination artificielle ou fécondation in vitro n'est pas successible sauf legs particulier mais il conserve un recours contre la succession en vertu d'une autre loi[133]. Pour l'Ontario, enfin, la Commission de réforme du droit de cette province recommande que l'enfant posthume soit successible à condition d'avoir été conçu avant la détermination des héritiers, à moins, bien entendu, d'un legs particulier[134].

Les pays qui s'opposent à l'utilisation posthume des gamètes et des embryons soutiennent qu'elle est contraire au bien-être de l'enfant, à qui il manquerait un parent[135].

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126. Voir, par exemple, CONSEIL DE L'EUROPE 1, princ. 19.

127. Voir, par exemple, NOUVELLE-GALLES DU SUD 4, par. 5.24 et rec. 16 ; DANEMARK 1, rec. 9.1, p. 125 ; CONSEIL DE L'EUROPE 1, princ. 18 ; ROYAUME-UNI 4, princ. 4, et ROYAUME-UNI 5, par. 11.22, rec. 45, p. 135 ; QUÉBEC 1, rec. 27, p. 40.

128. ONTARIO 1, rec. 30 ; ESPAGNE 1, art. 12 à 16.

129. Voir, par exemple, DANEMARK 1, rec. 9.2, p. 126 ; ESPAGNE 1, art. 3 et 20 ; CONSEIL DE L'EUROPE 1, princ. 16 ; LOUISIANE 2, art. 122 ; FRANCE 5, art. 10 — FRANCE 2, L. 669 ; QUÉBEC 1, p. 32, et rec. 22 et 27, pp. 39-40. *Contra* : NOUVELLE-GALLES DU SUD 4, rec. 14 ; VICTORIA 1, art. 9A ; ROYAUME-UNI 2, ann. 2, art. 3, et ROYAUME-UNI 5, par. 11.30, rec. 44, p. 135 ; voir aussi ALLEMAGNE 1, art. 1(1)v.

130. NOUVELLE-GALLES DU SUD 3, par. 12.4, rec. 28 et 29, NOUVELLE-GALLES DU SUD 4, rec. 38 et 39 ; ESPAGNE 1, art. 9, ESPAGNE 2, p. 237, et ESPAGNE 3, p. 243 ; ROYAUME-UNI 2, art. 28(6). Voir aussi ROYAUME-UNI 5, par. 4.4, 10.9 et 10.15, et ROYAUME-UNI 6, par. 59 et 60, où cette pratique est découragée. ONTARIO 1, rec. 20 et 21 ; QUÉBEC 5, rec. 35.

131. ROYAUME-UNI 2, par. 28(6), ROYAUME-UNI 5, par. 10.9 et 10.15, rec. 60 et 63, pp. 137-138, et ROYAUME-UNI 6, par. 59, 60 et 88.

132. ESPAGNE 1, art. 9.

133. NOUVELLE-GALLES DU SUD 1, art. 3 et 5A, NOUVELLE-GALLES DU SUD 3, par. 12.4, rec. 28, 29 et 31, et NOUVELLE-GALLES DU SUD 4, rec. 38.

134. ONTARIO 1, rec. 20 et 21.

135. DANEMARK 1, pp. 97 et 101, rec. 6.1 ; CONSEIL DE L'EUROPE 1, p. 25 et princ. 7(4) ; FRANCE 5, art. 10 et p. 27 — FRANCE 2, L. 668-3 ; SUÈDE 3 et SUÈDE 4, p. 6. Voir aussi ALLEMAGNE 1, art. 4 : par. 4(1) : [TRADUCTION] « Est passible d'une peine d'emprisonnement de trois ans ou d'une amende quiconque : [..] (iii) sciemment, féconde artificiellement un ovule avec le sperme d'un homme après le décès de ce dernier ». QUÉBEC 1, p. 21 et rec. 6, p. 38, QUÉBEC 4, p. 12, et QUÉBEC 5, rec. 35.

E. La filiation de l'enfant

La filiation de l'enfant né par suite d'un don de gamètes ou d'embryon est traitée plus fréquemment que la filiation de l'enfant né d'une femme porteuse[136].

1. Le don de gamètes et d'embryon

Pour un grand nombre de pays, le donneur ou la donneuse de gamètes n'a aucun lien de filiation ni aucune responsabilité parentale envers l'enfant né grâce à son don[137]. Toutefois, certains limitent l'application de ce principe aux seuls cas où le don est effectué sous surveillance médicale ou par l'entremise d'un centre autorisé[138]. Signalons qu'une loi récente du Royaume-Uni précise que le donneur de sperme doit avoir consenti au don pour ne pas être considéré comme le père de l'enfant[139].

La maternité légale est souvent établie au moyen d'une présomption qui tient pour mère la femme qui donne naissance à l'enfant[140]. Suivant la recommandation de la Commission de réforme du droit de l'Ontario, la femme qui porte un enfant dans l'intention de l'élever devrait être reconnue comme sa mère de façon concluante[141]. D'autre part, la législation espagnole prévoit que le couple marié qui a consenti à l'intervention ne peut contester la filiation maternelle[142].

Le mari de la femme qui donne naissance à l'enfant est tenu pour le père légal de l'enfant, soit par l'opération d'une présomption, soit en raison de son consentement à

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136. Voir aussi la section portant sur l'utilisation posthume des gamètes et des embryons.

137. Australie-Méridionale 1, art. 10*e* ; Australie-Occidentale 1, art. 7, Nouvelle-Galles du Sud 1, art. 6 ; Queensland 1, art. 15 à 18 ; Tasmanie 1, art. 10c ; Territoire du Nord 1, art. 5D, 5E et 5F ; Victoria 2, art. 10c à 10*f* ; Danemark 1, p. 96 ; Espagne 3, p. 243 ; Conseil de l'Europe 1, pp. 29-30 et princ. 14 ; New York 1, par. 2(*b*) et Missouri 1, art. 210.824 ; France 5, art. 11 — France 3, art. 342-9 ; Norvège 1, par. 15(2) (par suite de la modification du *Children Act*) ; Royaume-Uni 2, art. 28, Royaume-Uni 5, par. 4.22, 6.8 et 7.6, rec. 51 et 54, p. 136 et Royaume-Uni 6, par. 88 ; Colombie-Britannique 1, rec. 1 et 13 ; Ontario 1, rec. 19(2) et 21 ; Saskatchewan 1, p. 9 et art. 4 et Canada 2, p. 14 et rec. 1 ; Canada 5, pp. 33-34, rec. 18 ; Québec 1, rec. 12 et 13, p. 38 ; Québec 5, rec. 24 et 25, Québec 6, p. 60, et Québec 7, art. 579.

138. En Europe, lorsque le don n'est pas effectué par l'entremise d'un centre autorisé, le donneur est tenu à des obligations parentales et un lien de filiation avec l'enfant pourrait être établi : Conseil de l'Europe 1, p. 30, princ. 14(3). Voir aussi Saskatchewan 1, art. 2 et 4.

139. Royaume-Uni 2, par. 28(6).

140. Commonwealth d'Australie 1, art. 60B ; Australie-Méridionale 1, art. 10c ; Australie-Occidentale 1, art. 5 et 7 ; Nouvelle-Galles du Sud 4, rec. 37 ; Queensland 1, art. 17 ; Tasmanie 1, art. 10c ; Territoire du Nord 1, art. 5C ; Victoria 2, art. 10E ; Espagne 3, p. 242 ; Conseil de l'Europe 1, pp. 29-30, princ. 14 ; Arkansas 1, art. 9-10-201 ; Royaume-Uni 2, art. 27, Royaume-Uni 5, par. 6.8 et 7.6, rec. 54 et 55, pp. 136-137, et Royaume-Uni 6, par. 88 ; Canada 2, rec. 2 ; Québec 1, rec. 13, p. 38, et Québec 5, rec. 34.

141. Ontario 1, rec. 19(1).

142. Espagne 1, art. 8.

l'intervention[143], lequel serait présumé jusqu'à preuve du contraire dans plusieurs pays[144]. Selon la Commission de réforme du droit de la Saskatchewan, enfin, le consentement pourrait être donné avant ou après l'insémination[145].

Pour la plupart des pays, lorsque le couple n'est pas marié, le conjoint de fait peut généralement être reconnu comme le père de l'enfant s'il a consenti à l'intervention[146]. Selon la proposition de la Commission de réforme du droit de l'Ontario, le mari ou partenaire consentant de la femme qui porte l'enfant dans l'intention de l'élever serait, de façon concluante, tenu pour le père légal de l'enfant[147].

Le désaveu ou la contestation de la paternité se fait généralement par la preuve de l'absence de consentement ou du fait que l'enfant n'est pas né par suite de l'intervention, mais naturellement[148]. En France, le conjoint qui a consenti mais ne reconnaît plus l'enfant à la naissance reste responsable envers la mère et l'enfant. De plus, il est impossible à quiconque, y compris l'enfant, de contester ce lien de filiation pour cause d'absence de lien biologique[149].

L'enfant né grâce à la procréation médicalement assistée jouit des mêmes droits que l'enfant légitime conçu naturellement si le couple est marié et que le mari ait donné son

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143. COMMONWEALTH D'AUSTRALIE 1, art. 60B ; AUSTRALIE-MÉRIDIONALE 1, art. 10*d* ; AUSTRALIE-OCCIDENTALE 1, art. 6 ; NOUVELLE-GALLES DU SUD 1, art. 5 ; QUEENSLAND 1, art. 15 à 17 ; TASMANIE 1, art. 10c ; TERRITOIRE DU NORD 1, art. 5D ; VICTORIA 2, art. 10C à 10E ; ESPAGNE 3, p. 242 ; CONSEIL DE L'EUROPE 1, p. 30, princ. 14(2) ; NEW YORK 1, art. 1 ; MISSOURI 1, art. 210.824 ; ARKANSAS 1, art. 9-10-201 ; FRANCE 5, p. 29 (conformément au droit commun, FRANCE 3, art. 312) ; NORVÈGE 1, par. 15(2) (par suite de la modification de l'art. 9 du *Children Act*) ; ROYAUME-UNI 2, art. 28, ROYAUME-UNI 5, par. 4.17, 4.24, 4.25 et 7.6, rec. 50, 52, 53 et 55, pp. 136-137, et ROYAUME-UNI 6, par. 88 et 89 ; COLOMBIE-BRITANNIQUE 1, rec. 1 et 17 ; CANADA 3, rec. 1 ; ONTARIO 1, rec. 19(1) ; SASKATCHEWAN 1, p. 8 et art. 2(*a*) et 3 ; CANADA 2, rec. 3 ; QUÉBEC 1, p. 25 et rec. 11 et 12, p. 38 ; QUÉBEC 5, rec. 33, et QUÉBEC 7, art. 580 et 581. La Suède et une trentaine d'États américains ont adopté des dispositions législatives au même effet, en s'inspirant du *Uniform Parentage Act* (voir ÉTATS-UNIS 5, p. 244).

144. COMMONWEALTH D'AUSTRALIE 1, art. 60B ; AUSTRALIE-MÉRIDIONALE 1, art. 10*a* et 10*d*, AUSTRALIE-OCCIDENTALE 1, art. 3, 5 et 6 ; NOUVELLE-GALLES DU SUD 1, art. 3 et 5 ; QUEENSLAND 1, art. 13 et 15 à 17 ; TASMANIE 1, art. 10c ; TERRITOIRE DU NORD 1, art. 5A et 5D ; VICTORIA 2, art. 10A, 10C, 10D et 10E ; ROYAUME-UNI 5, par. 4.24, rec. 53, p. 136, et ROYAUME-UNI 6, par. 88 et 89 (projet de modification du *Family Law Reform Act* 1987, visant à inclure les dons d'ovules et d'embryons) ; ONTARIO 1, rec. 19(3), et CANADA 2, rec. 3.

145. SASKATCHEWAN 1, p. 8 et art. 3.

146. COMMONWEALTH D'AUSTRALIE 1, art. 60B ; AUSTRALIE-MÉRIDIONALE 1, art. 10*a* et 10*d* ; AUSTRALIE-OCCIDENTALE 1, art. 3, 5 et 6 ; NOUVELLE-GALLES DU SUD 1, art. 3 et 5 ; QUEENSLAND 1, art. 13 et 15 à 17 ; TERRITOIRE DU NORD 1, art. 5A et 5D ; VICTORIA 2, art. 10A, 10C à 10E ; ESPAGNE 1, art. 6, et ESPAGNE 3, p. 242 ; CONSEIL DE L'EUROPE 1, princ. 14(2) ; ROYAUME-UNI 2, art. 28 ; CANADA 2, rec. 3 ; QUÉBEC 5, rec. 34, et QUÉBEC 7, art. 581.

147. ONTARIO 1, rec. 19(1).

148. CONSEIL DE L'EUROPE 1, p. 30, princ. 14(2) ; LOUISIANE 1, art. 188 ; ROYAUME-UNI 5, par. 4.24, rec. 52, p. 136 ; ONTARIO 1, rec. 19(3) ; QUÉBEC 7, art. 580.

149. FRANCE 5, art. 11 et pp. 29-30 ; FRANCE 3, art. 342-10 et 342-11.

consentement[150]. Certains pays exigent que l'insémination ait été pratiquée sous surveillance médicale[151] et d'autres, que l'acte de naissance ne fasse aucune mention du mode de conception[152].

2. La maternité de substitution

Parmi les pays qui tentent de décourager la maternité de substitution, plusieurs recommandent que la présomption attribuant la maternité légale à la femme qui donne naissance à l'enfant s'applique en dépit du contrat conclu[153]. En Espagne, la loi ne permet pas à la femme de renoncer à l'avance à sa maternité par contrat[154]. Le rapport du Barreau du Québec précise d'autre part qu'aucun droit préférentiel à l'adoption ne devrait être accordé à la conjointe du père biologique[155]. Au Royaume-Uni, l'Interim Licensing Authority recommande que soit évitée la maternité de substitution par fécondation in vitro entre parents proches[156]. Enfin, certains organismes proposent de reconnaître aux enfants nés grâce à cette technique les droits d'accès à l'information reconnus aux enfants adoptés ou conçus par insémination artificielle[157].

Dans l'État américain de l'Arkansas, le père biologique et sa femme sont reconnus comme les parents de l'enfant conçu dans le cadre d'un contrat de maternité de substitution, bien que ce soit le nom de la femme porteuse qui figure sur le certificat de naissance[158]. Au Michigan, en cas de litige, la partie ayant la garde physique de l'enfant la conserve jusqu'à ce qu'un tribunal, au regard de l'intérêt véritable de l'enfant, en décide autrement[159].

L'Association du Barreau canadien, qui ne s'oppose pas à la maternité de substitution à titre gratuit et non contestée, propose que la législation sur l'adoption et la famille soit

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150. Conseil de l'Europe 1, pp. 29-30 ; Arkansas 1, art. 9-10-201 ; France 5, p. 29 (enfant légitime du mari, France 3, art. 312) ; Norvège 1, par. 15(2) ; Royaume-Uni 5, par. 4.17, 4.24 et 7.6, rec. 50, 52 et 55, pp. 136-137, et Royaume-Uni 6, par. 89 ; Colombie-Britannique 1, rec. 1 ; Canada 3, p. 37 et rec. 1 ; Ontario 1, rec. 21, et Saskatchewan 1, art. 3.

151. New York 1, art. 1 ; Saskatchewan 1, al. 2*a*) et *b*).

152. Nouvelle-Galles du Sud 3, par. 11.1 à 11.4, Nouvelle-Galles du Sud 4, rec. 41, p. 104 ; Commonwealth d'Australie 2, rec. X ; Espagne 1, art. 7 ; France 5, p. 29 ; Colombie-Britannique 1, rec. 17 ; Ontario 1, rec. 20, et Canada 2, p. 16, rec. 4. Voir cependant Royaume-Uni 5, par. 4.25, 6.8 et 7.6, et Royaume-Uni 6, par. 90, qui ne semblent pas défavorables à l'inscription du mode de conception au registre des naissances.

153. Nouvelle-Galles du Sud 5, rec. 9, pp. 60-62 ; Conseil de l'Europe 1, p. 30 et princ. 14 ; Espagne 1, art. 10 ; Royaume-Uni 2, art. 27, et Royaume-Uni 5, par. 8.20.

154. Espagne 1, art. 10, Espagne 2, p. 237, et Espagne 3, p. 242.

155. Québec 1, pp. 29-30 et rec. 21, p. 39. Voir aussi Nouvelle-Galles du Sud 5, rec. 10, pp. 62-65.

156. Royaume-Uni 4, princ. 13(*k*). Voir aussi Québec 5, rec. 58, où l'on se dit défavorable à la pratique des contrats de maternité de substitution avec transfert d'embryon.

157. Nouvelle-Galles du Sud 5, rec. 11 ; Québec 4, p. 20.

158. Arkansas 1, art. 9-10-201.

159. Michigan 1, art. 722.861, division 11.

modifiée pour faciliter la reconnaissance des parents sociaux comme parents légaux dans ces circonstances. Aucun droit de visite ou de garde ne serait accordé si la femme porteuse refuse de rendre l'enfant. Celle-ci pourrait en revanche réclamer au couple qui refuse d'adopter l'enfant une pension alimentaire pour celui-ci si elle le garde[160]. La position et les recommandations du New York Task Force on Life and the Law sont au même effet : en cas de conflit dans l'exécution d'une entente à titre gratuit, le tribunal devrait accorder la garde à la femme porteuse, à moins qu'il soit prouvé de façon claire et convaincante que l'intérêt de l'enfant serait mieux servi autrement[161].

La Commission de réforme du droit de l'Ontario favorise l'exécution du contrat en attribuant dès la naissance de l'enfant la maternité et la paternité au couple requérant. La femme porteuse ne pourrait changer d'avis ; il lui faudrait remettre l'enfant à ce moment, et pourrait y être forcée par ordonnance judiciaire[162].

II. L'innocuité des techniques de procréation médicalement assistée

Les normes d'application, la tenue des dossiers et l'accès à l'information, de même que la responsabilité du donneur et les recours de l'enfant, sont les thèmes qui reviennent régulièrement dans les lois et rapports examinés lorsqu'il s'agit d'assurer l'innocuité des techniques de procréation médicalement assistée.

A. Les normes d'application

Les normes d'application de la procréatique portent en général sur les risques physiques, la fréquence d'utilisation des gamètes d'un même donneur et les services de consultation.

1. Les risques physiques

Pour assurer la qualité des gamètes, les rapports recommandent que les mesures suivantes deviennent obligatoires : l'évaluation psychologique du donneur et de ses

160. Canada 2, pp. 26-33 et rec. 9c) à 9h) ; la femme porteuse aurait le même délai qu'en matière d'adoption pour décider si elle veut garder l'enfant.

161. New York 2, pp. 136-137, et art. 4 du *Proposed Surrogate Parenting Act*. Le tribunal doit aussi déterminer les droits de visite et de pension alimentaire en fonction du droit existant. Le fardeau de la preuve relatif à l'intérêt de l'enfant est plus élevé que la prépondérance de preuve, mais moins élevé que la preuve hors de tout doute raisonnable.

162. Ontario 1, rec. 49 et 56 à 59. Voir aussi New York 2, p. 99, où l'on cite le projet de loi de la Floride qui interdit à la femme porteuse de révoquer son consentement à l'adoption.

motivations[163], l'examen médical du donneur[164], le dépistage des maladies transmissibles ou héréditaires[165], le dépistage génétique ou la vérification des antécédents familiaux[166], le dépistage sanguin des anticorps contre le virus d'immuno-déficience humaine (VIH)[167] ou encore la répétition, au moins six mois après le don, du dépistage du VIH chez le donneur avant toute utilisation du sperme[168].

Dans certains pays, on exige ou, à tout le moins, recommande de n'utiliser que du sperme congelé[169], alors que d'autres jugent suffisant de s'en remettre aux lignes directrices du corps médical en matière de dépistage et de sélection des donneurs[170].

En ce qui a trait aux recommandations relatives à la conservation des gamètes et embryons, le délai maximum de conservation des gamètes varie généralement entre cinq et dix ans[171]. La congélation d'ovules non fécondés est souvent déconseillée[172]. Le délai

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163. Colombie-Britannique 1, rec. 10 ; Canada 3, p. 6 ; Canada 4, p. 7 ; Québec 5, rec. 14.

164. Delaware 1, art. 2801 ; Ohio 1, art. 3111.33 ; États-Unis 1, princ. VII, et États-Unis 2, p. 45S ; Royaume-Uni 5, par. 4.18 ; Colombie-Britannique 1, rec. 11 ; Canada 3, pp. 9-10, Canada 4, p. 6, et Canada 5, pp. 29-30, rec. 12 ; [Traduction] « Les Sociétés recommandent que les donneurs soient soumis aux épreuves de dépistage et analyses génétiques déterminées par la corporation professionnelle ».

165. Espagne 1, art. 5 ; Conseil de l'Europe 1, princ. 5 ; Ohio 1, art. 3111.33 ; Royaume-Uni 5, par. 4.18 ; Suède 3 ; Colombie-Britannique 1, rec. 11 ; Canada 3, rec. 2, et Canada 4, p. 6.

166. Nouvelle-Galles du Sud 3, par. 5.12 et 5.15 ; Queensland 3, p. 111 ; Espagne 1, art. 5 ; Conseil de l'Europe 1, princ. 5 ; États-Unis 1, princ. VII, États-Unis 2, p. 45S, et Ohio 1, art. 3111.33 ; Colombie-Britannique 1, rec. 11 ; Canada 3, pp. 7-9, rec. 2.2, et Canada 4, pp. 6-7. Voir aussi Québec 1, p. 23, où l'on recommande l'adoption de normes minimales et uniformes pour la sélection et l'appariement des donneurs.

167. États-Unis 1, princ. V, VI et VII ; Royaume-Uni 4, princ. 13(*h*) ; Suède 3 ; Canada 1, p. 29, Canada 4, p. 6, et Canada 5, pp. 38-39, rec. 22 ; Québec 1, p. 23, Québec 5, rec. 17, et Québec 6, p. 61. Les États-Unis et le Royaume-Uni recommandent également le dépistage du virus de l'hépatite B.

168. Louisiane 4, art. 1062.1, et États-Unis 1, princ. VII ; Suède 3 ; Canada 4, p. 6 ; Québec 4, p. 13 et rec. 2.7, Québec 5, pp. 89-92 et rec. 17, et Québec 6, pp. 43-45.

169. Danemark 1, p. 97 ; États-Unis 1, princ. VII(D), États-Unis 2, p. 44S, et Louisiane 4, art. 1062.1 (cette règle ne s'applique pas à l'insémination artificielle homologue) ; Royaume-Uni 4, princ. 13(*i*), et Royaume-Uni 5, par. 10.1 et rec. 29, p. 133 (sauf l'insémination artificielle homologue), Royaume-Uni 6, par. 44 ; Suède 3 ; Canada 4, p. 5, Canada 5, pp. 38-39, rec. 22 ; Québec 4, p. 13 et rec. 2.7, Québec 5, rec. 17, et Québec 6, p. 61.

170. Nouvelle-Galles du Sud 3, par. 5.12 et 9.11, rec. 4, 17 et 18 ; Royaume-Uni 5, par. 4.5 (pour l'insémination artificielle homologue) ; Ontario 1, rec. 8 (on recommande toutefois la tenue de consultations nationales aux fins d'uniformisation) ; Saskatchewan 1, p. 3, et Canada 2, p. 19 (les banques de gamètes provinciales se chargeraient d'assurer la qualité des gamètes et la sélection des donneurs).

171. Espagne 1, art. 11 ; Conseil de l'Europe 1, princ. 7(2) et 7(3) ; France 5, art. 10 et p. 23 — France 2, L. 668-3 ; Royaume-Uni 2, art. 14, Royaume-Uni 5, par. 10.8 et rec. 30, p. 133, et Royaume-Uni 6, par. 54. Voir aussi Québec 1, rec. 9, p. 38. Le lecteur trouvera au tableau III, *infra*, pp. 217-220, la liste des délais proposés.

172. Espagne 1, art. 11 ; États-Unis 2, p. 57S ; Norvège 1, art. 3 ; Royaume-Uni 4, princ. 11 (la congélation des ovules est permise mais leur implantation subséquente est interdite), et Royaume-Uni 5, par. 10.2 et rec. 9, p. 130 ; Québec 5, rec. 52.

recommandé pour la cryoconservation des embryons peut varier entre douze mois et dix ans[173] et l'ovule fécondé in vitro ne peut être conservé pendant plus de quatorze jours[174].

Plusieurs autorités se sont prononcées sur les risques occasionnés par la grossesse multiple, le nombre d'embryons à implanter et leur réduction subséquente[175]. De plus, le don ou transfert d'embryon de l'utérus d'une femme à celui d'une autre (par lavage utérin ou autrement) est généralement déconseillé en raison du caractère expérimental de la technique et du risque de grossesse auquel s'expose la donneuse[176].

2. La fréquence d'utilisation des gamètes d'un même donneur

On a recommandé de contrôler la participation des donneurs aux programmes de dons de gamètes en limitant soit le nombre d'utilisacions, soit le nombre d'enfants issus des gamètes du même donneur[177]. L'objectif visé est d'éviter les risques de consanguinité, ainsi que la transmission de maladies que les connaissances médicales actuelles ne permettent pas de détecter[178]. Par ailleurs, le rapport ontarien propose de laisser la détermination du nombre de fois que les gamètes d'un même donneur peuvent être utilisés au jugement du médecin et à la préférence des parties[179].

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173. Australie-Méridionale 2, par. 10(3) et 13(6) ; Nouvelle-Galles du Sud 4, rec. 2, pp. 55-56 et rec. 22, p. 86 ; Danemark 1, rec. 6.1, p. 124 ; Espagne 1, art. 11 ; Conseil de l'Europe 1, princ. 8(2) ; France 5, art. 30 — France 2, L. 670 ; Norvège 1, art. 3 ; Royaume-Uni 2, art. 14, Royaume-Uni 4, princ. 8, Royaume-Uni 5, par. 10.10, rec. 31, p. 133, et Royaume-Uni 6, par. 54 ; Ontario 1, rec. 32 ; Canada 2, rec. 10(*g*) ; Québec 1, pp. 32-34, et Québec 5, rec. 46.

174. Australie-Méridionale 2, par. 10(3) et 13(6) (le délai de congélation ne peut dépasser la limite de la période où l'embryon peut encore être implanté), et Nouvelle-Galles du Sud 4, rec. 2, pp. 55-56 et rec. 15, p. 72 ; Espagne 1, art. 15 et 20 ; Conseil de l'Europe 1, princ. 17.2(*b*) ; France 5, art. 10 — France 2, L. 672 (délai de sept jours) ; Royaume-Uni 2, art. 3, Royaume-Uni 4, princ. 7 et 8 ; Royaume-Uni 5, par. 11.22, rec. 12 et 44, pp. 130 et 135, Royaume-Uni 6, par. 33 et 34 ; Ontario 1, rec. 31 ; Canada 2, rec. 10c), et Québec 1, rec. 27, pp. 39-40.

175. Danemark 1, p. 100 : la réduction est permise si des raisons médicales l'exigent. Espagne 1, art. 4 : les embryons sont implantés en nombre suffisant pour assurer des chances raisonnables de grossesse. Royaume-Uni 4, princ. 12 : le nombre d'embryons pouvant être implantés est limité à trois. Royaume-Uni 5, par. 5.4 : le nombre d'embryons à implanter est laissé au jugement du médecin. Allemagne 1, art. 1 : le nombre d'embryons pouvant être implantés est limité à trois. Ontario 1, rec. 26 : le nombre d'embryons pouvant être implantés ne devrait pas être limité. Québec 5, rec. 42 et 43 : on accepte l'implantation de plusieurs embryons mais on déplore la technique de la réduction.

176. Australie-Méridionale 2, par. 10(3) et 13(6) ; Conseil de l'Europe 1, p. 28, princ. 12 ; États-Unis 2, p. 545 ; Espagne 1, art. 20 ; France 5, art. 10 — France 2, L. 669 ; Royaume-Uni 5, par. 7.5 et rec. 8, p. 130 ; Allemagne 1, art. 1 ; Canada 5, p. 24, rec. 8, et Québec 1, p. 19 et rec. 4, p. 38. *Contra* : Ontario 1, p. 146 et rec. 1.

177. Espagne 1, art. 5 ; États-Unis 1, princ. VII(C), et États-Unis 2, p. 455 ; Royaume-Uni 5, par. 4.26 et 6.6, rec. 22 et 26, pp. 132-133 ; Colombie-Britannique 1, rec. 12, Québec 4, p. 13, rec. 2.4, et Québec 5, rec. 22. Bien qu'elle soit recommandée, la limite n'est pas chiffrée dans les rapports suivants : Nouvelle-Galles du Sud 3, par. 9.15, rec. 20 et 21 ; Danemark 1, règl. 3.1, p. 132 (devra être fixée par le Conseil danois de la santé) ; Conseil de l'Europe 1, princ. 10 ; France 5, art. 10 — France 2, L. 668-9 (devra être fixée par arrêté du ministre de la Santé) ; Royaume-Uni 6, par. 87 ; Canada 3, p. 13 et rec. 2.4, et Québec 1, p. 24.

178. Voir, par exemple, Conseil de l'Europe 1, pp. 26-27.

179. Ontario 1, rec. 16.

3. Les services de consultation

Par souci de protection des participants aux programmes de procréation médicalement assistée, des services de consultation sont recommandés dans certains pays[180] et obligatoires dans d'autres[181]. Par exemple, la loi de l'État de Victoria les rend obligatoires avant toute intervention, y compris le don de gamètes[182].

B. La tenue des dossiers et l'accès à l'information

La tenue des dossiers et la centralisation de l'information, ainsi que l'accès à celle-ci, ont fait l'objet de recommandations diverses.

1. La tenue des dossiers et la centralisation de l'information

Si la nécessité de tenir des dossiers fait l'unanimité, on ne peut en dire autant des modalités de leur tenue. Cette responsabilité peut revenir au médecin ou à la clinique[183] et un système permettant de relier le dossier du donneur à celui de la receveuse, tout en conservant l'anonymat, est généralement recommandé[184]. Un rapport australien recommande que, lorsque l'enfant naît à la suite d'un don de gamètes ou d'embryon, les dossiers soient gardés indéfiniment[185].

La mise sur pied d'un registre central des dossiers des donneurs et de ceux des enfants nés de la procréatique, ainsi que l'obligation des médecins et des cliniques de fournir les

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180. Nouvelle-Galles du Sud 3, par. 7.11, rec. 13, Nouvelle-Galles du Sud 4, rec. 10, pp. 67-68, et Commonwealth d'Australie 2, rec. VII ; Danemark 1, p. 99 ; États-Unis 1, princ. IV, et États-Unis 2, pp. 47S et 60S ; Royaume-Uni 2, par. 13(6) et ann. 3, art. 3, Royaume-Uni 4, princ. 13(*g*) et 15(*a*), Royaume-Uni 5, par. 3.4, 6.6 et 7.7, rec. 19 et 26, pp. 132-133, et Royaume-Uni 6, par. 56, 60 et 77 ; Colombie-Britannique 1, p. 10 et rec. 10 ; Canada 1, pp. 28-29, Canada 3, p. 28 et rec. 3.3, et Canada 4, p. 7 ; Québec 1, p. 24 et rec. 5, p. 38, Québec 4, p. 10, rec. 1.5, 2.3, 2.5 et 3.1, et Québec 5, p. 58, rec. 36.

181. Victoria 1, art. 9 à 13A et 18 ; Espagne 1, art. 2 ; Conseil de l'Europe 1, princ. 4(2).

182. Victoria 1, art. 9 à 13A et 18. Le conseiller doit être approuvé par le Ministre. Le médecin qui pratique l'intervention doit s'assurer que le couple, et non seulement la personne qui subit l'intervention, a reçu des services de consultation et qu'un suivi est prévu.

183. Australie-Méridionale 2, par. 13(3) et (6) (médecin), Nouvelle-Galles du Sud 1, art. 16 (médecin), Nouvelle-Galles du Sud 3, par. 13.30 et rec. 37 (médecin et clinique), et Nouvelle-Galles du Sud 4, rec. 27 à 29, pp. 90-92 (clinique) ; Conseil de l'Europe 1, princ. 6 (médecin et clinique) ; Espagne 1, art. 19 (médecin) ; États-Unis 2, pp. 44S et 76S (médecin) ; Royaume-Uni 4, princ. 13(*b*) et 14(*b*) (clinique) ; Canada 3, p. 25 (médecin).

184. États-Unis 2, p. 76S ; Ohio 1, art. 3111.36 ; Suède 3 ; Colombie-Britannique 1, rec. 16 ; Canada 3, pp. 19-26, rec. 3.2 ; Ontario 1, rec. 22(3) et 22(5) ; Québec 5, rec. 24, et Québec 6, p. 60.

185. Commonwealth d'Australie 2, rec. II. Voir aussi Suède 1, art. 3, et Suède 3 : les dossiers sont conservés pendant soixante-dix ans.

renseignements pertinents sont fréquemment recommandées[186]. Toutefois, certains craignent que le respect de l'anonymat soit compromis par un tel registre[187].

2. L'accès à l'information

L'anonymat du donneur et des parties est une règle générale suivie par tous les pays[188], à l'exception de la Suède où l'anonymat du donneur a cédé le pas au droit primordial de l'enfant de connaître ses origines génétiques[189]. Certains précisent que la confidentialité des renseignements obtenus des donneurs est garantie au même titre que celle dont jouit tout patient[190] et les modalités du consentement des parties aux conditions d'accès à l'information sont abordées à quelques reprises[191].

L'accès aux données obéit à un régime différent selon que l'information est identifiante ou non. Par ailleurs, les circonstances qui justifient la levée de l'anonymat sont diverses : la personne y consent[192], l'existence d'un motif raisonnable ou d'un cas extrême[193], la

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186. VICTORIA 1, art. 22 ; QUEENSLAND 3, rec. B(3) (xi) et (xii) ; COMMONWEALTH D'AUSTRALIE 2, rec. IV et VIII ; ESPAGNE 1, art. 5 ; PENNSYLVANIE 1, art. 3213 ; ROYAUME-UNI 2, art. 31, ROYAUME-UNI 4, princ. 13(*b*), ROYAUME-UNI 5, par. 13.9, rec. 16, p. 131, et ROYAUME-UNI 6, par. 15, 79, 80 et 85 ; CANADA 1, p. 29, CANADA 2, pp. 24-25, rec. 5 , QUÉBEC 4, p. 25.

187. NOUVELLE-GALLES DU SUD 3, par. 13.30, rec. 37, et NOUVELLE-GALLES DU SUD 4, par. 5.52 ; CANADA 3, p. 24.

188. NOUVELLE-GALLES DU SUD 1, art. 14, NOUVELLE-GALLES DU SUD 3, par. 8.2 et 8.13, rec. 14 et 16, NOUVELLE-GALLES DU SUD 4, rec. 34, p. 97 ; QUEENSLAND 3, rec. B(3) (xiii) ; VICTORIA 1, art. 23 ; COMMONWEALTH D'AUSTRALIE 2, rec. I ; DANEMARK 1, rec. 8.1, p. 125 et règl. 5.1, p. 133 ; ESPAGNE 1, art. 2, 5, 19 et 20 ; CONSEIL DE L'EUROPE 1, princ. 13 ; ÉTATS-UNIS 1, princ. VII(*c*), et ÉTATS-UNIS 2, pp. 44S, 50S, 52S, 75S et 76S ; FRANCE 5, art. 10 — FRANCE 2, L. 668-8, et FRANCE 4, art. 378 ; NORVÈGE 1, art. 10 ; ROYAUME-UNI 2, art. 31 à 33 et 41, ROYAUME-UNI 4, princ. 13(*j*), ROYAUME-UNI 5, par. 3.2, 6.6 et 7.7, rec. 18 et 26, pp. 131 et 133, ROYAUME-UNI 6, par. 83 et 84 ; COLOMBIE-BRITANNIQUE 1, rec. 1 et 9 ; ONTARIO 1, rec. 22(4) ; SASKATCHEWAN 1, p. 10 et par. 5(1) ; CANADA 2, p. 24, et CANADA 4, p. 10 ; QUÉBEC 1, rec. 15 et 16, pp. 38-39, QUÉBEC 5, rec. 29 et 31, et QUÉBEC 7, art. 583.

189. SUÈDE 1, art. 4, et SUÈDE 5, p. 389 : l'enfant a accès au dossier complet du donneur lorsqu'il est jugé suffisamment mûr. Voir aussi DANEMARK 1, rec. 8.1*a*, p. 125, et règl. 5.1*a*, p. 132, où la minorité des membres partagent aussi cet avis à l'égard du don de gamètes ou d'embryon.

190. NOUVELLE-GALLES DU SUD 1, art. 14, NOUVELLE-GALLES DU SUD 3, par. 8.13 et 14.10, et NOUVELLE-GALLES DU SUD 4, rec. 34, p. 97 ; ONTARIO 1, rec. 22(2).

191. Voir, par exemple, COMMONWEALTH D'AUSTRALIE 2, rec. VII : les parties doivent consentir formellement aux conditions d'accès à l'information avant le début de toute intervention. QUÉBEC 6, p. 60 : le donneur doit obligatoirement être avisé de la nature des renseignements auxquels l'enfant peut avoir accès ; voir aussi SUÈDE 3.

192. AUSTRALIE-MÉRIDIONALE 2, art. 18 ; NOUVELLE-GALLES DU SUD 1, art. 15 (le droit d'accès n'est pas ouvert à l'enfant âgé de moins de dix-huit ans, à moins qu'il ne soit marié) ; NOUVELLE-GALLES DU SUD 3, par. 8.2 et 13.23, rec. 15 et 32, NOUVELLE-GALLES DU SUD 4, rec. 31, pp. 92-93 ; VICTORIA 1, art. 22 ; COMMONWEALTH D'AUSTRALIE 2, rec. VII, version 2 (le droit d'accès ne s'ouvre que lorsque l'enfant atteint l'âge de dix-huit ans, la demande doit être présentée par écrit par une personne ayant un intérêt légitime, et les parents doivent consentir si l'information demandée concerne l'enfant) ; CANADA 5, pp. 35-37, rec. 19 à 21, et QUÉBEC 5, rec. 31 et 32 (le donneur a le droit de refuser la divulgation de son identité et les parents peuvent refuser au nom de l'enfant s'il n'est pas au courant de son mode de conception).

193. COMMONWEALTH D'AUSTRALIE 2, rec. VII ; ÉTATS-UNIS 2, p. 44S ; QUÉBEC 1, rec. 14 à 16, pp. 38-39.

décision d'une autorité déterminée[194], le danger pour la vie ou la santé[195], les besoins de l'organisme qui applique les techniques ou qui effectue de la recherche et, enfin, les exigences de l'application de la loi[196]. Par ailleurs, on envisage la levée éventuelle de l'anonymat, dans des circonstances qui restent encore à arrêter[197]. D'aucuns permettent déjà à l'enfant majeur d'avoir accès sur demande aux données identifiantes[198].

Le droit d'accès à l'information non identifiante du dossier du donneur est reconnu à l'enfant soit lorsqu'il atteint l'âge de dix-huit ans[199], soit lorsqu'il atteint l'âge de quatorze ans[200], soit sans restriction à cet égard[201]. Toutefois, certaines autorités exigent une raison médicale, telle la découverte d'une maladie génétique ou héréditaire[202]. Enfin,

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194. Nouvelle-Galles du Sud 1, art. 15, Nouvelle-Galles du Sud 3, par. 8.2, rec. 15, Nouvelle-Galles du Sud 4, rec. 31, pp. 92-93 (permission du Conseil biomédical) ; Commonwealth d'Australie 2, rec. VII ; Espagne 2, p. 237 (dans le cadre de procédures judiciaires) ; Suède 1, art. 5 (dans le cadre d'un procès où la paternité est en litige) ; Canada 2, rec. 6 (ordonnance d'un tribunal permettant d'avoir accès au registre provincial) ; Québec 5, rec. 29 et 32 (accès permis au médecin et au donneur lorsque cela est nécessaire pour des raisons médicales, et sur ordonnance du tribunal).

195. Espagne 1, art. 5 et 8 (preuve d'un danger pour la vie de l'enfant ; toutefois, la divulgation de l'identité ne fait pas preuve de la paternité légale) ; Canada 2, rec. 6 (l'accès au registre provincial serait conditionné par la nécessité d'ordre médical) ; Canada 3, p. 29 (maladie congénitale ou héréditaire de l'enfant lorsque ce renseignement présente une importance pour la santé du donneur) ; Saskatchewan 1, p. 12 et art. 5 (pour l'insémination artificielle hétérologue, l'information peut être consultée par les médecins et le personnel médical ou sous leur surveillance ; elle est recevable en preuve au cours de procédures judiciaires à condition que l'identité du donneur ne soit pas révélée) ; Québec 1, p. 27 et rec. 15-16, pp. 38-39 (sur permission du tribunal lorsqu'une vie humaine est en cause ou pour éviter des troubles psychologiques majeurs chez l'enfant ; les contacts directs ne sont toutefois pas obligatoires) ; Québec 5, rec. 29 et 32 (accès permis au médecin et au donneur lorsque cela est nécessaire pour des raisons médicales) ; Québec 7, art. 583.

196. Australie-Méridionale 2, art. 18 ; Nouvelle-Galles du Sud 1, art. 15, Nouvelle-Galles du Sud 3, par. 8.2, rec. 15, et Nouvelle-Galles du Sud 4, rec. 31, pp. 92-93.

197. Conseil de l'Europe 1, princ. 13 (les États membres sont libres de légiférer pour permettre l'accès à l'identité du donneur et au mode de conception) ; Royaume-Uni 6, par. 84 ; Québec 6, pp. 60-61 ; Victoria 4, par. 3.14 et 3.36 ; Nouvelle-Galles du Sud 4, rec. 32, p. 95.

198. Commonwealth d'Australie 2, rec. VII, version I ; Royaume-Uni 2, art. 31 ; Québec 4, p. 13 et rec. 2.9. Voir à ce sujet Québec 2.

199. Nouvelle-Galles du Sud 5, rec. 11, pp. 66-67 ; Royaume-Uni 5, par. 4.21, 6.6 et 7.7, rec. 26, p. 133 (voir la rec. 20 dans la version anglaise du rapport), et Royaume-Uni 6, par. 83. Voir aussi Espagne 1, art. 5 et 19.

200. Québec 4, p. 13 et rec. 2.9 ; Québec 5, rec. 28.

201. Nouvelle-Galles du Sud 1, art. 17 (la personne qui a un motif valable fondé sur le bien-être ou la santé d'une des parties peut avoir accès à l'information sur simple entente avec la personne responsable des dossiers), Nouvelle-Galles du Sud 3, par. 13.23 et rec. 33, Nouvelle-Galles du Sud 4, rec. 30, 32 et 33, pp. 92-95 (l'information peut être communiquée à l'enfant, au donneur ou à toute personne sur preuve d'un motif valable ou sur décision du Conseil biomédical) ; Victoria 1, art. 20 et 23 et ann. 7 ; Commonwealth d'Australie 2, rec. VII (la demande est présentée par écrit au registre de l'État par toute personne ayant un intérêt légitime ou par les parents de l'enfant si celui-ci est mineur) ; États-Unis 1, princ. VII(*c*), et États-Unis 2, p. 44S ; Royaume-Uni 2, art. 31 (l'information pouvant être communiquée au mineur est limitée à l'existence de liens génétiques avec un conjoint éventuel ; des services de consultation doivent être proposés) ; Ontario 1, rec. 22(7) (la question serait laissée à la discrétion du médecin traitant) ; Canada 5, pp. 35-37, rec. 19 à 21 ; Québec 6, p. 60.

202. Conseil de l'Europe 1, princ. 13 ; Colombie-Britannique 1, rec. 16.

il est quelquefois précisé que la décision de dévoiler à l'enfant le secret de ses origines est de nature purement privée[203].

C. La responsabilité du donneur et les recours de l'enfant

Quelques pays ont érigé en infraction le fait pour un donneur de cacher intentionnellement des renseignements nécessaires ou de donner de faux renseignements[204]. En France, par contre, l'avant-projet de loi stipule que le donneur n'a aucune responsabilité envers l'enfant[205].

Sur le plan civil, la reconnaissance d'un recours spécifique à l'enfant ayant subi un préjudice n'est généralement pas recommandée puisque le médecin reste soumis aux règles de la responsabilité civile[206].

Enfin, signalons que, dans le rapport au ministre de la Santé nationale et du Bien-être social, on envisage la possibilité de créer un organisme qui serait chargé d'examiner toute poursuite judiciaire résultant de la naissance d'un enfant atteint d'une malformation congénitale ou d'une maladie génétique grave[207].

III. Le contrôle médical et l'encadrement de la procréatique

Des dispositions législatives ou réglementaires uniformes, à l'échelle étatique, provinciale ou nationale, sont recommandées dans divers pays[208], alors que d'autres

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203. Voir, par exemple, COMMONWEALTH D'AUSTRALIE 2, rec. I ; CANADA 3, p. 28, et ONTARIO 1, rec. 22(7) ; QUÉBEC 5, rec. 24.

204. NOUVELLE-GALLES DU SUD 1, art. 11, NOUVELLE-GALLES DU SUD 3, par. 5.18, rec. 5, NOUVELLE-GALLES DU SUD 4, rec. 35, p. 98 ; VICTORIA 1, art. 27 ; ONTARIO 1, rec. 23. Voir aussi ÉTATS-UNIS 2, p. 24S (il s'agit d'une obligation d'ordre moral plutôt que d'un agissement engageant la responsabilité pénale), et CANADA 3, p. 23 (le respect de l'anonymat du donneur est conditionné par la divulgation de renseignements exacts, au meilleur de la connaissance de celui-ci, sur ses antécédents génétiques et médicaux).

205. FRANCE 5, art. 11 — FRANCE 3, art. 342-9.

206. NOUVELLE-GALLES DU SUD 3, par. 14.9, rec. 41, et NOUVELLE-GALLES DU SUD 4, rec. 11, p. 69 ; ESPAGNE 1, art. 19 ; COLOMBIE-BRITANNIQUE 1, rec. 1 et 15, ONTARIO 1, rec. 22, 24 et 25 ; SASKATCHEWAN 1, pp. 4-5.

207. CANADA 3, p. 23.

208. Voir, par exemple, NOUVELLE-GALLES DU SUD 3, par. 5.12, rec. 4 (recrutement des donneurs et dépistage) ; ONTARIO 1, rec. 9 (recrutement des donneurs et dépistage) ; CANADA 3, rec. 2 et p. 16 (acquisition, préservation et importation du sperme humain) ; CANADA 2, rec. 10*e*) (recherche) ; CANADA 5, p. 39, rec. 23 : [TRADUCTION] « Les Sociétés approuvent la mise sur pied de banques de sperme centralisées (régionales) pour la sélection, l'entreposage et la disposition ultime du sperme donné congelé. Ces banques devraient être *légalement tenues* de se conformer aux normes établies par les sociétés professionnelles, telles que la Société canadienne de fertilité et d'andrologie, pour la sélection des donneurs des points de vue médical et génétique, le dépistage des maladies sexuellement transmissibles et la tenue des dossiers. » [Mis en italiques par nos soins.] QUÉBEC 1, rec. 2, p. 37.

préfèrent laisser certaines questions au jugement professionnel des médecins[209], des comités d'éthique[210] et des groupes de travail compétents[211]. L'étude de certains sujets a également été recommandée[212] mais, en général, les recommandations portent sur le contrôle médical et sur l'encadrement des techniques.

A. Le contrôle médical de la procréatique

La nécessité d'un contrôle médical des techniques de procréation médicalement assistée ne fait pas de doute. Les lois établissent que les techniques doivent être appliquées par des médecins ou des spécialistes, ou sous leur surveillance, ou encore dans des hôpitaux ou centres autorisés[213]. Les rapports exigent une surveillance médicale ou l'intervention d'un médecin, en précisant que les traitements de procréation médicalement assistée relèvent de l'exercice de la médecine[214] et doivent être administrés dans des cliniques ou centres autorisés[215].

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209. Voir, par exemple, NOUVELLE-GALLES DU SUD 3, rec. 7, 12, 17 et 36 (formulaires de consentement, services de consultation, examens de dépistage, tenue des dossiers) ; ÉTATS-UNIS 2, pp. 75S-80S ; ONTARIO 1, rec. 16 et 24 (fréquence d'utilisation des gamètes d'un même donneur et accès à l'information non identifiante) ; SASKATCHEWAN 1, p. 3.

210. Voir, par exemple, NOUVELLE-GALLES DU SUD 4, rec. 1, 2 et 21, et par. 5.9 à 5.11 (code de déontologie pratique pour la conservation et l'utilisation des embryons conçus par fécondation in vitro) ; ÉTATS-UNIS 2, p. 77S ; ROYAUME-UNI 4, princ. 13(*a*) et 14(*a*) (chaque centre doit faire approuver les techniques qu'il applique par un comité d'éthique multidisciplinaire comptant des femmes) ; SUÈDE 5, p. 389 (recherche et expérimentation).

211. Voir, par exemple, ROYAUME-UNI 5, par. 2.17 et rec. 37, p. 134 (groupe de travail national composé de représentants des services de santé et de praticiens, et chargé de l'élaboration de lignes directrices concernant l'organisation des services) ; QUÉBEC 5, rec. 60 et 61 (groupe de travail multidisciplinaire chargé d'examiner la recherche sur l'embryon et de proposer des principes directeurs au ministre de la Santé).

212. Voir, par exemple, ÉTATS-UNIS 2, p. 75S (effets à long terme sur les patients) ; CANADA 1, p. 30 (infertilité, effets des facteurs mutagènes, origines de l'infertilité masculine, programmes de dépistage de la chlamydia et de la gonorrhée) ; CANADA 3, rec. 2.5 (effets à long terme des critères de sélection des donneurs) ; QUÉBEC 5, rec. 6, 19 et 44 (causes et traitements de l'infertilité, contraceptifs, solutions de rechange à la stérilisation volontaire précoce, amélioration des taux de réussite de l'utilisation du sperme congelé, risques de grossesse multiple en fonction du nombre d'embryons transférés, amélioration des chances de grossesse lors du transfert d'un seul embryon) ; QUÉBEC 6, p. 60 (infertilité, fécondité, contraceptifs, solutions de rechange à la stérilisation précoce).

213. AUSTRALIE-MÉRIDIONALE 2, art. 13, NOUVELLE-GALLES DU SUD 1, VICTORIA 1, art. 7, 9 à 13A et 17 ; ESPAGNE 1, art. 18 à 20 ; LOUISIANE 2, art. 128, OHIO 1, art. 3111.32 ; FRANCE 1, art. 2 ; NORVÈGE 1, art. 2 et 14 ; SUÈDE 1, art. 3, SUÈDE 2, art. 3 et 4, et SUÈDE 5, pp. 388-389 ; ALLEMAGNE 1, art. 9, 11 et 12.

214. NOUVELLE-GALLES DU SUD 3, par. 4.7, rec. 2, et NOUVELLE-GALLES DU SUD 4, rec. 5, p. 62 ; DANEMARK 1, pp. 97 et 99 ; CONSEIL DE L'EUROPE 1, p. 21 et princ. 2 ; ÉTATS-UNIS 2, pp. 75S-77S ; FRANCE 5, art. 10 — FRANCE 2, L. 668-2 et L. 675 ; ROYAUME-UNI 5, par. 3.1, 4.5 et 13.7, rec. 3, p. 129 ; COLOMBIE-BRITANNIQUE 1, rec. 6, ONTARIO 1, rec. 3, CANADA 2, pp. 17-18 et rec. 7.

215. AUSTRALIE-MÉRIDIONALE 3, rec. 7, NOUVELLE-GALLES DU SUD 3, par. 4.6 et 4.7, rec. 1 et 2, NOUVELLE-GALLES DU SUD 4, rec. 1, 4 et 6 ; QUEENSLAND 3, rec. B(1) (iii) ; DANEMARK 1, pp. 97 et 99 ; CONSEIL DE L'EUROPE 1, p. 21 et princ. 2 ; FRANCE 5, art. 10 — FRANCE 2, L. 668-2 et L. 675 (pour la fécondation in vitro et le transfert d'embryon) ; ROYAUME-UNI 5, par. 4.16, 5.10, 6.6, 7.4 et 13.7, rec. 3 à 7, pp. 129-130, et ROYAUME-UNI 6, par. 15, 20, 21 et 27 (pour l'insémination artificielle hétérologue, la fécondation in vitro, le don d'ovule et le don d'embryon) ; QUÉBEC 4, p. 13, rec. 2.2 et 6.2, QUÉBEC 5, rec. 8, 9, 36, 37 et 64, et QUÉBEC 6, p. 60 (limitation du nombre des centres). *Contra* : ONTARIO 1, p. 153 et rec. 4.

En ce qui a trait à la conservation, la cession et l'importation des gamètes et des embryons, la Colombie-Britannique recommande la création d'une banque de sperme responsable devant les autorités publiques[216]. Le Barreau du Québec propose pour sa part d'interdire la création de banques d'embryons dont la seule activité serait le stockage aux fins de don ou d'expérimentation[217]. Selon la majorité des recommandations, seules les banques de gamètes ou autres organismes autorisés pourraient se livrer à de telles activités[218].

B. L'encadrement de la procréatique

Diverses recommandations ont été faites au sujet de l'encadrement des techniques de procréation médicalement assistée.

En Nouvelle-Galles du Sud, il est recommandé que le Conseil biomédical, organisme multidisciplinaire créé par la loi et composé d'un nombre égal de femmes et d'hommes, établisse les conditions d'obtention des permis ainsi que les normes d'application des techniques, de recherche et de conservation de l'information, au moyen d'un code d'éthique. Le Conseil est chargé de conseiller le ministre de la Santé, d'informer le public, de revoir les délais de conservation des gamètes et des embryons, de trancher les litiges relatifs à l'accès à l'information et, enfin, d'approuver les projets de recherche. L'ensemble du système d'autorisation serait toutefois administré par le ministère de la Santé[219]. Par ailleurs, la loi de cet État qui porte sur l'insémination artificielle ne prévoit aucune mesure spéciale d'encadrement.[220]

Une loi adoptée par l'État d'Australie-Méridionale établit le South Australian Council on Reproductive Technology, organisme multidisciplinaire formé d'un nombre égal de femmes et d'hommes. Sa mission consiste à élaborer un code d'éthique comprenant les normes de recherche et d'application des techniques, à conseiller le ministère de la Santé

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216. COLOMBIE-BRITANNIQUE 1, rec. 19 et 21.

217. QUÉBEC 1, rec. 26, p. 39.

218. DANEMARK 1, rec. 6.1, p. 124 et règl. 3.1, p. 132 ; ESPAGNE 1, art. 20 (le commerce, l'importation et l'exportation d'embryons sont interdits) ; CONSEIL DE L'EUROPE 1, p. 21 et princ. 2 ; DELAWARE 1, art. 2801 ; FRANCE 1, art. 2 ; FRANCE 5, art. 10 — FRANCE 2, L. 668-2 et L. 676-4 ; NORVÈGE 1, art. 3 et 14 ; ROYAUME-UNI 2, art. 3, 4 et 41, et ann. 2, art. 2, ROYAUME-UNI 5, par. 13.7 et 13.13, rec. 3, 17 et 49, pp. 129, 131 et 136, et ROYAUME-UNI 6, par. 27, 48, 49, 62 et 63 ; SUÈDE 1, art. 6 ; COLOMBIE-BRITANNIQUE 1, rec. 19 à 21 (on favorise la création d'une banque publique, de préférence à des banques commerciales ou privées, à moins que celles-ci ne soient soumises au contrôle des autorités fédérales) ; CANADA 2, rec. 8 (l'ABC recommande la création de banques provinciales), et CANADA 3, p. 15 et rec. 2.5 (l'importation de sperme par des banques commerciales et la création de banques échappant à l'autorité des pouvoirs publics est interdite tant que le fédéral n'aura pas pris des règlements établissant des normes nationales de qualité) ; ONTARIO 1, rec. 17 et 18 (la CRDO permettrait aux banques de fonctionner sur une base commerciale, pour peu qu'elles soient assujetties à un contrôle public) ; QUÉBEC 1, p. 25 et rec. 7, p. 38.

219. NOUVELLE-GALLES DU SUD 4, rec. 1, 2, 4 et 6. La moitié des membres du Conseil seraient des femmes puisque les conséquences de la FIV sont plus importantes pour elles. Voir aussi NOUVELLE-GALLES DU SUD 3, par. 4.6 et 4.7, rec. 1 et 2.

220. NOUVELLE-GALLES DU SUD 1.

sur les questions liées à la procréation médicalement assistée, ainsi que sur les conditions d'octroi des permis, à formuler les conditions d'octroi des permis de recherche, à effectuer certaines recherches, à informer le public et à faire rapport au ministère et au Parlement. Le ministre de la Santé octroie les permis[221].

Dans l'État de Victoria, la loi prévoit un système d'accréditation des cliniques et des conseillers par le ministre de la Santé. La recherche et l'octroi des permis à cet égard relèvent du Standing Review and Advisory Committee, organisme multidisciplinaire qui conseille l'État sur toute question liée à la procréation médicalement assistée et prépare un rapport annuel à l'intention du Parlement[222].

Le Conseil d'éthique danois propose l'établissement d'un organisme de contrôle chargé d'approuver les projets de recherche et d'accréditer les cliniques désirant offrir des services de procréation médicalement assistée[223].

En Espagne, la législation qui traite de tous les aspects de la procréation médicalement assistée prévoit la mise en place d'une commission nationale sur la reproduction assistée. Cet organisme multidisciplinaire conseillerait l'État et collaborerait à la compilation des données et à la formulation des critères relatifs au fonctionnement des cliniques et services. Il pourrait aussi être appelé à autoriser les projets de recherche[224].

Au Royaume-Uni, les premiers rapports ont recommandé la mise en place d'une autorité indépendante du gouvernement, dotée d'un pouvoir réglementaire et chargée de la surveillance et de la réglementation des services d'infertilité, de la conservation des gamètes et des embryons, de la recherche, des permis et, enfin, d'un registre central des dossiers[225]. À titre provisoire, la Voluntary Licensing Authority — maintenant appelée Interim Licensing Authority —, organisme créé conjointement par le Medical Research Council et le Royal College of Obstetricians and Gynaecologists, remplit ces fonctions en invitant les centres à obtenir l'accréditation et à détenir un permis[226]. La nouvelle loi adoptée en novembre 1990, le *Human Fertilisation and Embryology Act 1990*, reprend ces recommandations en créant un organisme de contrôle appelé Human Fertilisation and Embryology Authority qui, à son tour, est chargé de la mise sur pied d'un ou de plusieurs comités responsables de l'octroi et de la révocation des permis. Il assume la responsabilité du registre des dossiers et conseille les titulaires de permis. Il a pour mission d'établir un code de pratique qui traite du bien-être de l'enfant et de la conduite des activités reliées à la procréation médicalement assistée[227].

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221. Australie-Méridionale 2, art. 5, 10 à 12 ; voir aussi art. 13 à 16, au sujet des conditions de délivrance des permis et des pouvoirs du ministère.

222. Victoria 1, art. 7 à 9A et 29.

223. Danemark 1, rec. 12.1 à 16.1, pp. 127-128. Des organismes régionaux pourraient aussi être formés, voir Danemark 1, pp. 139-147.

224. Espagne 1, art. 14 à 16 et 21 ; l'établissement d'un registre central des données est prévu à l'art. 5.

225. Royaume-Uni 5, par. 13.3 à 13.13, rec. 1 à 3, 16, 17 et 49, pp. 129, 131 et 136, et Royaume-Uni 6, par. 13 à 27, 79 et 85.

226. Royaume-Uni 6, par. 9. Voir aussi Royaume-Uni 4, pp. 45 et 49.

227. Royaume-Uni 2, art. 5, 8, 9, 23, 25 et 31.

Au Québec, le rapport du ministère de la Santé et des Services sociaux propose l'élaboration de normes minimales de pratique et d'éthique qui seraient intégrées à son mécanisme d'accréditation et d'évaluation des cliniques. Constituées en un réseau provincial, les cliniques seraient chargées de la collecte et de la publication de données uniformes relatives aux services. L'observation de l'évolution de la pratique serait laissée aux milieux universitaires et aux organismes qui s'y intéressent[228]. Pour sa part, le Conseil du statut de la femme suggère que le ministère de la Santé et des Services sociaux crée un comité ad hoc multidisciplinaire responsable de l'élaboration des normes d'accréditation — auxquelles devraient se conformer les centres spécialisés — et des mécanismes d'évaluation, de suivi et de contrôle de la qualité des méthodes[229]. Le gouvernement devrait également mettre sur pied un organisme consultatif à vocation éthique, composé de représentants de la société plutôt que d'experts, et chargé de le conseiller et d'émettre des avis d'ordre éthique en matière de procréation médicalement assistée[230]. Enfin, une loi cadre devrait être adoptée[231].

Bref, en ce qui a trait à l'encadrement de la procréation médicalement assistée, les organismes dont on recommande la création ont des responsabilités semblables et une structure analogue.

Bien que les démarches entreprises dans le monde afin de cerner les enjeux de la procréatique ne soient pas toutes de même envergure, il ressort de l'étude des dispositions législatives et des recommandations que l'avènement des techniques de procréation médicalement assistée est accepté avec plus ou moins de réserves et qu'un consensus s'est formé sur plusieurs principes de base.

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228. QUÉBEC 5, rec. 65 à 76.

229. QUÉBEC 4, p. 25, rec. 6.1, 6.5 et 6.6. Le nombre de centres spécialisés accrédités serait limité à cinq, soit les centres existant actuellement. La durée du mandat de ce comité serait courte, après quoi les recommandations relatives aux conditions entourant la pratique feraient place à des normes édictées par le Ministère pour la reconnaissance des cliniques. Un suivi et une évaluation périodiques seraient nécessaires.

230. QUÉBEC 4, pp. 25-26, rec. 6.5. Le mandat inclurait la gestion qualitative des naissances, l'évaluation et le suivi des méthodes et de la recherche, ainsi que la diffusion de l'information au public. Il évaluerait de façon globale les services offerts en ayant accès aux rapports annuels des centres accrédités. Les femmes devraient y être fortement représentées.

231. QUÉBEC 4, p. 26, rec. 6.6.

TABLEAU I : Admissibilité à la procréatique (sauf la maternité de substitution)

Texte*	Couple hétérosexuel non marié	Femme seule	Femmes formant un couple homosexuel
AUSTRALIE-MÉRIDIONALE 2	Autorisé (moyennant 5 ans de cohabitation)	Exclue	Exclues
NOUVELLE-GALLES DU SUD 1 NOUVELLE-GALLES DU SUD 3 (IA) NOUVELLE-GALLES DU SUD 4 (FIV)	Autorisé	Non exclue mais critères très limitatifs	—
VICTORIA 1	Autorisé	Exclue pour FIV	Exclues pour FIV
CANADA 2	Autorisé	Non exclue	—
CANADA 4	Autorisé	Autorisée	Autorisées
CANADA 5	Autorisé	Autorisée	Autorisées
COLOMBIE-BRITANNIQUE 1 (IA)	Autorisé	Non exclue	Non exclues
ONTARIO 1	Autorisé	Autorisée	—
QUÉBEC 1	Autorisé	Exclue	Exclues
QUÉBEC 4	Autorisé	Exclue	Exclues
QUÉBEC 5	Autorisé	Autorisée pour IA	Autorisées pour IA
CONSEIL DE L'EUROPE 1	Autorisé	Exclue	Exclues
DANEMARK 1	Autorisé	Autorisée	Autorisées
ESPAGNE 1	Autorisé	Autorisée	Autorisées
ÉTATS-UNIS 1	Autorisé	Autorisée	—

*Voir la liste des textes cités, *infra*, pp. 225-231.

TABLEAU I : Admissibilité à la procréatique (sauf la maternité de substitution) (*suite et fin*)

Texte*	Couple hétérosexuel non marié	Femme seule	Femmes formant un couple homosexuel
ÉTATS-UNIS 2	Autorisé	Autorisée dans certaines circonstances	—
FRANCE 5	Autorisé	Exclue	Exclues
NORVÈGE 1	Exclu	Exclue	Exclues
ROYAUME-UNI 2	Autorisé	Non exclue	—
ROYAUME-UNI 5	Autorisé	Non exclue mais préfère couple hétérosexuel	Non exclues mais préfère couple hétérosexuel
SUÈDE 1 (IA) SUÈDE 3	Autorisé	Exclue	Exclues
SUÈDE 2 (FIV)	Autorisé	Exclue	Exclues

*Voir la liste des textes cités, *infra*, pp. 225-231.

TABLEAU II : Critères d'accès à la procréatique (sauf la maternité de substitution)

Texte*	Infertilité ou affection génétique	Bien-être de l'enfant	Stabilité	Consentement du conjoint	Autres critères	Autorité décisionnelle
AUSTRALIE-MÉRIDIONALE 2	Exigée	—	—	—	—	—
NOUVELLE-GALLES DU SUD 1 NOUVELLE-GALLES DU SUD 3 (IA) NOUVELLE-GALLES DU SUD 4 (FIV)	Considérée chez couples	Considéré	Considérée	—	Nécessité de consultation, santé physique et psychique des parents éventuels	Médecin ; sanction professionnelle si le médecin ne considère pas les critères, même s'ils ne sont pas obligatoires
VICTORIA 1	1 an de traitements infructueux exigé, sauf pour IA	Exigé	—	Exigé sauf pour IA	Consultation obligatoire	Médecin
CANADA 2	—	—	—	—	—	Médecin
CANADA 4	—	—	Exigée	—	—	—
COLOMBIE-BRITANNIQUE 1 (IA)	—	—	—	Exigé chez couples mariés	Qualités parentales exigées comme pour adoption	Médecin suivant critères ; appel possible
ONTARIO 1	Exigée chez couple	—	Exigée	—	—	Médecin suivant critères ; appel possible
QUÉBEC 1	Exigée (infertilité seulement)	—	Exigée chez couples non mariés	—	—	—
QUÉBEC 4	Exigée	—	—	—	—	—

*Voir la liste des textes cités, *infra*, pp. 225-231.

TABLEAU II : Critères d'accès à la procréatique (sauf la maternité de substitution) (*suite*)

Texte*	Infertilité ou affection génétique	Bien-être de l'enfant	Stabilité	Consentement du conjoint	Autres critères	Autorité décisionnelle
QUÉBEC 5	Exigée	—	—	—	—	—
CONSEIL DE L'EUROPE 1	Exigée	Exigé	—	—	Chances de succès raisonnables, risques limités pour santé mère ou enfant	Médecin
DENMARK 1	—	—	—	Exigé	—	—
ESPAGNE 1	—	—	—	Exigé chez couples mariés	Chances de succès raisonnables, bonne santé physique et psychologique, majorité de la femme	—
ÉTATS-UNIS 1	—	—	—	Exigé	—	—
FRANCE 5	Exigée	—	—	Exigé	L'opération doit être effectuée par un médecin ou sous sa responsabilité	Sanction pénale pour quiconque contrevient aux critères établis dans l'avant-projet de loi
NORVÈGE 1	Exigée	—	—	Exigé	Évaluation médicale et psychosociale du couple	Médecin
ROYAUME-UNI 2	—	Exigé	—	—	—	—
ROYAUME-UNI 5	—	—	—	Recommandé	—	Médecin qui doit motiver refus

*Voir la liste des textes cités, *infra*, pp. 225-231.

TABLEAU II : Critères d'accès à la procréatique (sauf la maternité de substitution) (*fin*)

Texte*	Infertilité ou affection génétique	Bien-être de l'enfant	Stabilité	Consentement du conjoint	Autres critères	Autorité décisionnelle
SUÈDE 1 (IA) SUÈDE 3	—	Exigé	—	Exigé	Évaluation médicale, psychologique et sociale du couple	Médecin ; appel possible
SUÈDE 2 (FIV)	—	—	—	Exigé	—	—

*Voir la liste des textes cités, *infra*, pp. 225-231.

TABLEAU III : Délais de conservation et commerce des gamètes et des embryons*

Texte**	Délai		Paiements autorisés		Commerce	
	Gamètes	Embryons	Gamètes	Embryons	Gamètes	Embryons
AUSTRALIE-MÉRIDIONALE 2	—	10 ans, révisé annuellement (donneur)	—	—	—	—
NOUVELLE-GALLES DU SUD 1 (IA)	—	—	Somme fixe ou remboursement frais (sperme)	—	Prohibé	—
NOUVELLE-GALLES DU SUD 3 (IA)	—	—	Somme fixe et remboursement frais néces-saires ou raison-nables (sperme)	—	—	—
NOUVELLE-GALLES DU SUD 4 (FIV)	—	10 ans	—	—	—	—
VICTORIA 1	—	—	Frais déplacement, médicaux et autres	—	Prohibé	Prohibé
CANADA 1	—	—	—	—	Interdit	Interdit
CANADA 2	—	5 ans	—	—	—	—
CANADA 3	—	—	Inconvénients, temps, frais de déplacement (sperme)	—	—	—

*Dans le présent tableau, le terme « prohibé » suppose l'intervention du droit criminel ou pénal, tandis que le terme « interdit » évoque tout autre type de sanction non spécifiée.
**Voir la liste des textes cités, *infra*, pp. 225-231.

TABLEAU III : Délais de conservation et commerce des gamètes et des embryons* (*suite*)

Texte**	Délai		Paiements autorisés		Commerce	
	Gamètes	Embryons	Gamètes	Embryons	Gamètes	Embryons
CANADA 4 (IA)	—	—	Frais et inconvénients (sperme)	—	—	—
CANADA 5	—	—	Frais et inconvénients	—	Si le financement public est insuffisant, possibilité de mettre sur pied des banques à but lucratif	—
COLOMBIE-BRITANNIQUE 1 (IA)	—	—	Frais, temps, perte salaire (sperme)	—	—	—
ONTARIO 1	—	10 ans	Frais raisonnables, temps et inconvénients ; pourrait être plus élevé pour ovule ; paiement pour douleurs exclu	—	Banques commerciales permises (selon réglementation)	Banques commerciales permises (selon réglementation)
QUÉBEC 1	À fixer	À fixer	Frais réels	—	Interdit	Interdit
QUÉBEC 4	—	—	Aucune rémunération (sperme)	—	—	—

*Dans le présent tableau, le terme « prohibé » suppose l'intervention du droit criminel ou pénal, tandis que le terme « interdit » évoque tout autre type de sanction non spécifiée.
**Voir la liste des textes cités, *infra*, pp. 225-231.

TABLEAU III : Délais de conservation et commerce des gamètes et des embryons* (*suite*)

Texte**	Délai		Paiements autorisés		Commerce	
	Gamètes	Embryons	Gamètes	Embryons	Gamètes	Embryons
QUÉBEC 5	—	2 ans (peut être prolongé dans certaines circonstances)	Frais raisonnables, à la charge des receveuses (sperme)	—	Interdit	Interdit
QUÉBEC 6	—	—	—	—	—	Interdit
CONSEIL DE L'EUROPE 1	À fixer	À fixer	Frais déplacement et autres, perte salaire	Frais déplacement et autres, perte salaire	Interdit	Interdit
DANEMARK 1	—	1 an	—	—	—	Interdit
ESPAGNE 1	5 ans	5 ans	—	—	—	Interdit
ÉTATS-UNIS 1	—	—	Frais et temps (sperme)	—	—	—
ÉTATS-UNIS 2	—	—	Frais et temps (sperme) Frais, temps, risques et inconvénients (ovule)	Frais et inconvénients	—	—
FRANCE 5	À fixer	5 ans	Frais, perte salaire exclue	—	Profit prohibé	—
NORVÈGE 1	—	1 an	—	—	—	—

*Dans le présent tableau, le terme « prohibé » suppose l'intervention du droit criminel ou pénal, tandis que le terme « interdit » évoque tout autre type de sanction non spécifiée.
**Voir la liste des textes cités, *infra*, pp. 225-231.

TABLEAU III : Délais de conservation et commerce des gamètes et des embryons* (*fin*)

Texte**	Délai		Paiements autorisés		Commerce	
	Gamètes	Embryons	Gamètes	Embryons	Gamètes	Embryons
ROYAUME-UNI 2	10 ans	5 ans	—	—	Prohibé	Prohibé
ROYAUME-UNI 4	—	10 ans, révisé tous les 2 ans	—	—	Interdit (ovules)	—
ROYAUME-UNI 5	Révisé tous les 5 ans	10 ans, révisé tous les 5 ans	Frais (sperme)	—	Autorisé si accord de l'organisme de contrôle	Autorisé si accord de l'organisme de contrôle
ROYAUME-UNI 6	10 ans	5 ans	Frais raisonnables	Frais raisonnables	Autorisé si accord de l'organisme de contrôle	Autorisé si accord de l'organisme de contrôle
SUÈDE 1 (IA) SUÈDE 2 (FIV)	—	—	—	—	Prohibé	—

*Dans le présent tableau, le terme « prohibé » suppose l'intervention du droit criminel ou pénal, tandis que le terme « interdit » évoque tout autre type de sanction non spécifiée.
**Voir la liste des textes cités, *infra*, pp. 225-231.

TABLEAU IV : Maternité de substitution*

Texte**	Position générale	Intervention d'intermédiaire(s)	Publicité	Paiement	Contrat
ALLEMAGNE 1	Prohibée	Prohibée	—	—	—
AUSTRALIE 1	Commercialisation prohibée	Prohibée	Prohibée	Prohibé	Nul
AUSTRALIE-MÉRIDIONALE 1	Commercialisation prohibée	Prohibée si paiement	Prohibée	Prohibé pour intermédiaires	Nul
COMMONWEALTH D'AUSTRALIE 3	Permise sous contrôle strict	Contrôlée	Contrôlée	—	Nul
NOUVELLE-GALLES DU SUD 5	Découragée ; commercialisation prohibée	Prohibée (y compris professionnels de la santé et avocats)	Prohibée	Prohibé	Nul
QUEENSLAND 2	Prohibée	Prohibée	Prohibée	Prohibé	Nul
VICTORIA 1	Commercialisation prohibée	Prohibée si paiement	Prohibée	Prohibé	Nul
CANADA 2	Opposition à la prohibition des contrats de maternité de substitution ; commercialisation prohibée	—	—	Prohibé	Valide mais inopposable à la femme porteuse
CANADA 5	Permise pour raison médicale à titre expérimental	—	—	Permis pour la femme porteuse pour frais directs et indirects	—

*Dans le présent tableau, le terme « prohibé(e) » suppose l'intervention du droit criminel ou pénal, tandis que le terme « interdit(e) » évoque tout autre type de sanction non spécifiée.
**Voir la liste des textes cités, *infra*, pp. 225-231.

TABLEAU IV : Maternité de substitution* (*suite*)

Texte**	Position générale	Intervention d'intermédiaire(s)	Publicité	Paiement	Contrat
ONTARIO 1	Réglementation des contrats	Réglementée	—	Permis pour la femme porteuse si approuvé par tribunal	Exécutoire si approuvé par le tribunal
QUÉBEC 1	Strictement interdite	Prohibée	—	—	Nul
QUÉBEC 4	Empêcher les contrats de maternité de substitution ; commercialisation prohibée	Prohibée	Interdite	—	—
QUÉBEC 5	Opposition générale ; commercialisation prohibée	Prohibée	Interdite pour les intermédiaires	—	—
QUÉBEC 6	Interdite	Interdite	Interdite	—	—
CONSEIL DE L'EUROPE 1	Commercialisation interdite, États membres peuvent permettre entente altruiste	Interdite (sauf services médicaux en cas exceptionnels)	Interdite	Interdit	Nul
ESPAGNE 1	Découragée	—	—	—	Nul

*Dans le présent tableau, le terme « prohibé(e) » suppose l'intervention du droit criminel ou pénal, tandis que le terme « interdit(e) » évoque tout autre type de sanction non spécifiée.
**Voir la liste des textes cités, *infra*, pp. 225-231.

TABLEAU IV : Maternité de substitution* (*suite*)

Texte**	Position générale	Intervention d'intermédiaire(s)	Publicité	Paiement	Contrat
ÉTATS-UNIS 2	Opposition à la prohibition légale, permise pour raison médicale à titre d'expérimentation clinique	Autorisée si frais limités aux services professionnels	—	Indemnité pour frais et inconvénients de femme porteuse permise, et peut-être plus ; frais des intermédiaires	—
MICHIGAN 1	Commercialisation prohibée	Prohibée si paiement	—	Prohibé sauf frais engagés par femme porteuse	Nul
NEW YORK 2	Commercialisation prohibée	Prohibée si paiement (frais du médecin pour IA et FIV exclus)	—	Prohibé sauf frais engagés par femme porteuse (un affidavit déclarant tous paiements reçus doit être soumis au tribunal) ; perte salaire exclue	Nul
FRANCE 4 FRANCE 5	Commercialisation prohibée	Prohibée	—	—	Nul

*Dans le présent tableau, le terme « prohibé(e) » suppose l'intervention du droit criminel ou pénal, tandis que le terme « interdit(e) » évoque tout autre type de sanction non spécifiée.
**Voir la liste des textes cités, *infra*, pp. 225-231.

TABLEAU IV : Maternité de substitution* (*fin*)

Texte**	Position générale	Intervention d'intermédiaire(s)	Publicité	Paiement	Contrat
ROYAUME-UNI 1	Commercialisation prohibée	Prohibée si paiement	Prohibée	Prohibé pour intermédiaires	Nul
ROYAUME-UNI 5	Commercialisation prohibée	Prohibée pour organismes à but lucratif ou non (y compris les professionnels)	—	—	Nul
ROYAUME-UNI 6	Découragée ; commercialisation prohibée	Prohibée pour les agences commerciales	—	—	Nul

*Dans le présent tableau, le terme « prohibé(e) » suppose l'intervention du droit criminel ou pénal, tandis que le terme « interdit(e) » évoque tout autre type de sanction non spécifiée.
**Voir la liste des textes cités, *infra*, pp. 225-231.

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ANNEXE B

Proposition en vue d'une loi sur la procréation médicalement assistée

Remarques

Le texte qui suit n'est pas en soi un projet de loi sur la procréation médicalement assistée. Dans le cadre d'une politique législative globale sur ce sujet, nous proposons une ébauche de la structure que pourrait prendre la législation réglementant les principaux aspects de cette nouvelle technologie. Dans cette optique, nous n'avons pas tenu compte du partage des compétences entre les différents paliers de gouvernement. Il va de soi que, dans le contexte constitutionnel canadien, une réglementation comme celle qui est proposée ici est tributaire d'accords entre les autorités législatives du fédéral, des provinces et des territoires. Or, les détails de ces accords débordent le cadre du présent document de travail. Afin de présenter un texte le plus complet possible, nous avons dû, dans certains cas, adopter une position un peu plus catégorique que dans nos recommandations, et nous avons tenu pour acquis que les ententes nécessaires entre les différents paliers de gouvernement seraient réalisées.

Outre ces ententes et mesures législatives, il faudrait évidemment que les provinces et territoires prennent sur eux de modifier leur législation en matière, notamment, de filiation et de successions.

PROPOSITION EN VUE D'UNE LOI SUR LA PROCRÉATION MÉDICALEMENT ASSISTÉE

TITRE ABRÉGÉ

1.

DÉFINITIONS

2. Les définitions suivantes s'appliquent à la présente loi.

« accréditation »

« clinique accréditée »

« dépôt »

« don »

« embryon »

« gamète »

« importation »

« inspecteur »

« procréation médicalement assistée »

« procréatique »

« prédisposition génétique »

« organisme national »

« registre central »

« services de consultation »

« trait génétique »

etc.

DÉCLARATION DE PRINCIPES

3. La présente loi repose sur les principes suivants :

a) Les techniques de procréation médicalement assistée devraient être mises au point et utilisées en conformité avec les principes de l'égalité et de la justice, et de façon à respecter le caractère sacré de la vie ainsi que la dignité et l'inviolabilité de la personne.

b) L'utilisation d'une technique de procréation médicalement assistée en vue d'éviter la transmission d'un trait ou d'une prédisposition génétiques est inacceptable sauf dans les cas expressément prévus.

c) La commercialisation de la procréation médicalement assistée est inacceptable.

d) L'accès aux services de procréation médicalement assistée ne devrait pas être limité en fonction de critères liés à la situation de famille, à l'état matrimonial ou à l'orientation sexuelle du candidat.

e) Toute personne devrait avoir la possibilité, grâce à des services de consultation, d'obtenir toute l'information nécessaire avant de décider de recourir aux techniques de procréation médicalement assistée.

f) Il est essentiel d'établir des normes destinées à protéger la santé publique dans le contexte de l'application des techniques de procréation médicalement assistée.

ACCÈS AUX SERVICES DE PROCRÉATION MÉDICALEMENT ASSISTÉE

4. Limitation de l'accès

Nul ne devrait se voir refuser l'accès aux services de procréation médicalement assistée à moins que la rareté des ressources n'exige qu'une sélection soit exercée parmi les candidats. Le cas échéant, la situation de famille, l'état matrimonial ou l'orientation sexuelle du candidat ne devraient pas compter parmi les critères de sélection.

GAMÈTES ET EMBRYONS

5. Utilisation des gamètes et des embryons

(1) Gamètes. L'utilisation des gamètes devrait être limitée à la fécondation, à l'expérimentation et à la destruction ; toutefois, la fécondation devrait être prohibée au-delà du délai fixé par règlement pour la congélation [recommandations 6(4) et 12(2)]. D'autre part, le sperme donné ne devrait être utilisé pour la fécondation qu'après que le donneur aura été soumis à des analyses adéquates pour le dépistage du virus du sida [recommandation 11].

(2) Embryons. L'utilisation des embryons devrait être limitée à l'implantation, à l'expérimentation et à la destruction ; toutefois, l'implantation devrait être prohibée au-delà du délai fixé par règlement pour la congélation [recommandations 5(3) et 12(1)].

(3) Infraction.

6. Sélection des gamètes et des embryons

(1) Limitation. Afin d'éviter de donner prise à l'eugénisme, la sélection des gamètes et des embryons en fonction de qualités particulières devrait être prohibée [recommandation 2].

(2) Exception. Toutefois, une telle sélection devrait être permise lorsqu'elle a pour but de prévenir la transmission de maladies génétiques graves [recommandation 2].

(3) Infraction.

7. Commercialisation

(1) Don de gamètes ou d'embryon. La commercialisation du don de gamètes ou d'embryon devrait être interdite [recommandation 3(1)].

(2) Exception. Seul le remboursement des frais raisonnables engagés par le donneur devrait être autorisé [recommandation 3(1)].

(3) Banques de gamètes ou d'embryons. Il devrait être interdit aux banques de gamètes ou d'embryons d'exercer leurs activités dans un but lucratif [recommandation 3(2)].

(4) Exception. Les banques devraient pouvoir se faire rembourser les frais raisonnables afférents à leurs activités et à leur fonctionnement [recommandation 3(2)].

(5) Infraction.

8. Autorité sur les gamètes et les embryons en cas de dépôt ou de don

(1) Autorité sur les gamètes. L'autorité sur les gamètes devrait être attribuée au géniteur [recommandation 6(1)].

(2) Autorité sur l'embryon.

a) L'autorité sur l'embryon issu des gamètes d'un couple devrait être partagée par les partenaires.

b) L'autorité sur l'embryon issu des gamètes d'un seul des partenaires d'un couple et d'un donneur devrait être exercée exclusivement par le conjoint lié génétiquement à l'embryon.

c) L'autorité sur l'embryon issu des gamètes de deux donneurs devrait être exercée par la banque ou la clinique qui en a la possession.
[Recommandation 5(2).]

(3) Dépôt de gamètes.

a) La personne qui décide de déposer ses gamètes en vue d'un usage personnel futur devrait être tenue, avant le dépôt, d'exprimer par écrit sa volonté quant au sort des gamètes.

b) L'expression écrite de la volonté du déposant doit prévoir le sort des gamètes dans les cas suivants, notamment : décès du titulaire de l'autorité, abandon du projet parental et expiration du délai de congélation.

c) Le déposant devrait pouvoir modifier l'expression de sa volonté quant au sort des gamètes au moyen d'une déclaration écrite faite avant la conception d'embryons ou l'utilisation à laquelle les gamètes étaient destinés.
[Recommandation 6(2).]

(4) Dépôt d'embryon.

a) Avant de concevoir un embryon en vue d'un usage personnel futur, le titulaire éventuel de l'autorité sur l'embryon devrait être tenu d'exprimer par écrit sa volonté quant au sort de l'embryon. Dans les cas où l'autorité serait exercée par les deux partenaires d'un couple, leur volonté commune devrait être exprimée dans une seule et même déclaration.

b) L'expression écrite de la volonté du titulaire de l'autorité sur l'embryon doit prévoir le sort de celui-ci dans les cas suivants, notamment : décès du ou des titulaires de l'autorité, abandon du projet parental, expiration du délai de congélation, divorce ou autre conflit entre les titulaires de l'autorité sur l'embryon.

c) Le titulaire de l'autorité sur l'embryon devrait pouvoir modifier l'expression de sa volonté quant au sort de celui-ci au moyen d'une déclaration écrite faite avant que l'embryon ait été utilisé aux fins prévues. Dans le cas où l'autorité serait exercée par les deux partenaires d'un couple, toute modification devrait se faire d'un commun accord.
[Recommandations 5(1) et (2).]

(5) Don de gamètes.

a) La personne qui fait don de ses gamètes devrait être tenue, avant l'exécution du don, de faire une déclaration écrite exprimant son consentement au don et énumérant les conditions auxquelles celui-ci est assujetti quant à l'utilisation des gamètes.

b) Le donneur devrait pouvoir retirer son consentement ou modifier ces conditions au moyen d'une déclaration écrite avant la conception d'embryons ou l'utilisation des gamètes aux fins prévues.
[Recommandation 6(3).]

(6) Don d'embryon.

a) Le titulaire de l'autorité sur un embryon qui décide de donner celui-ci devrait être tenu, avant l'exécution du don, de faire une déclaration écrite exprimant son

consentement au don et énumérant les conditions auxquelles celui-ci est assujetti quant à l'utilisation de l'embryon. Dans les cas où l'autorité serait exercée par les deux partenaires d'un couple, leur volonté commune devrait être exprimée dans une seule et même déclaration.

b) Le donneur devrait pouvoir retirer son consentement ou modifier ces conditions au moyen d'une déclaration écrite avant l'utilisation de l'embryon aux fins prévues. Dans les cas où l'autorité serait exercée par les deux partenaires d'un couple, toute modification devrait se faire d'un commun accord.
[Recommandation 5(4).]

(7) Infraction.

9. Importation de gamètes et d'embryons

(1) Restriction. L'importation des gamètes et des embryons devrait être réservée aux banques accréditées. Les gamètes et embryons importés devraient également répondre aux normes nationales établies [recommandation 14].

(2) Infraction.

CLINIQUES ET BANQUES

10. Restriction des services

(1) Cliniques. L'application des différentes techniques de procréation médicalement assistée devrait être réservée aux cliniques accréditées [recommandation 21(2)].

(2) Banques. La conservation des gamètes et des embryons devrait être réservée aux banques de gamètes et d'embryons accréditées [recommandation 21(2)].

(3) Infraction.

11. Services de consultation

Toute clinique qui offre des services en matière de procréation médicalement assistée devrait avoir l'obligation d'offrir à toute personne qui y a recours, et ce, avant, pendant et après l'application d'une technique, des services de consultation permettant à cette personne d'obtenir auprès d'experts (médecins, psychologues, etc.) l'aide et l'information dont elle peut avoir besoin [recommandation16].

12. Tenue et utilisation des dossiers

(1) Obligation de tenir des dossiers. Les cliniques devraient être tenues de maintenir des dossiers (concernant le donneur ou la donneuse, la receveuse et l'enfant) permettant au médecin de relier le donneur ou la donneuse à la receveuse, tout en garantissant l'anonymat des parties [recommandation 17(1)].

(2) Limitation de l'information à conserver. L'information recueillie devrait être limitée à ce qui est nécessaire à la poursuite des objectifs suivants : permettre l'accès à l'information médicale et génétique qui pourrait être nécessaire à l'efficacité des soins médicaux dispensés à l'enfant ; satisfaire les besoins psychologiques de l'enfant ; permettre une préparation adéquate des rapports cliniques et entreprendre des études sur les effets à long terme des différentes techniques de procréation médicalement assistée [recommandation 17(2)].

(3) Protection de la confidentialité. Les cliniques devraient être garantes de la confidentialité de l'information qu'elles ont en leur possession [recommandation 17(3)].

(4) Accès à l'information — anonymat. À la demande des parents légaux ou de l'enfant, l'information non identifiante, notamment les renseignements d'ordre social (comme l'origine ethnique, la profession, le niveau d'instruction, l'appartenance religieuse et les centres d'intérêt du donneur ou de la donneuse) devrait pouvoir être divulguée. En revanche, l'information identifiante ne devrait pouvoir être divulguée que si le donneur ou la donneuse y consent [recommandation 18].

(5) Exception. L'identité du donneur ou de la donneuse qui omet de fournir des renseignements ou qui fournit de faux renseignements quant à ses antécédents médicaux ou à son patrimoine génétique devrait pouvoir être révélée au ministère public en vue de poursuites pénales liées à cette réticence ou à cette déclaration mensongère [recommandation 19].

(6) Infraction.

13. Rapport annuel des cliniques

(1) Obligation de produire un rapport annuel. Toute clinique devrait avoir l'obligation de présenter un rapport annuel écrit à un registre central [recommandation 9].

(2) Contenu du rapport. Le contenu minimal du rapport annuel devrait être établi par règlement et les données devraient être présentées dans la forme prescrite [recommandation 9]. En outre, les cliniques devraient avoir l'obligation d'enregistrer et de motiver le nombre d'embryons implantés au cours de chaque cycle de traitement [recommandation 15].

(3) Infraction.

14. Mise sur pied d'un organisme national

Les autorités fédérales, provinciales et territoriales, de concert avec les spécialistes du milieu, devraient mettre sur pied un organisme national de réglementation en matière de procréation médicalement assistée [recommandation 22(1)].

15. Attributions de l'organisme

(1) Établissement d'un système d'accréditation. L'organisme national devrait mettre sur pied un système d'accréditation des cliniques offrant des services de procréation médicalement assistée et des banques de gamètes et d'embryons [recommandation 21(1)].

(2) Règlements. L'organisme national devrait être habilité à prendre des règlements sur les questions suivantes [recommandation 22(2)*b*)] :

a) les critères d'accréditation des cliniques et des banques ;

b) les normes concernant la sélection des donneurs de gamètes et d'embryons [recommandation 10] et le nombre de fois que les gamètes d'un même donneur peuvent être utilisés [recommandation 13] ;

c) l'établissement de normes quant à la sélection, à la conservation [recommandation 10] et à l'importation de gamètes et d'embryons [article 9] ;

d) les délais de congélation des gamètes et des embryons [article 5] ;

e) les prohibitions relatives à la sélection des gamètes et des embryons [article 6] et à la commercialisation du don de gamètes ou d'embryon [article 7] ;

f) le remboursement des frais engagés par les donneurs et par les banques [article 7] ;

g) l'exercice de l'autorité sur les gamètes et les embryons, notamment l'assujettissement du don à des conditions et l'expression de la volonté du titulaire en cas de dépôt [article 8] ;

h) la composition et les fonctions des services de consultation établis par les cliniques [article 11] ;

i) la tenue de dossiers par les cliniques et le contenu de ces dossiers [paragraphes 12(1) et (2)] ;

j) les modalités de la divulgation par les cliniques de renseignements identifiants et non identifiants au sujet des donneurs [paragraphes 12(3) et (4)] ;

k) le contenu du rapport annuel que les cliniques sont tenues de fournir au registre central [paragraphes 13(1) et (2)].

(3) Attributions supplémentaires. L'organisme national devrait avoir les attributions suivantes :

a) prendre les mesures nécessaires à l'observation de la loi et des règlements ;

b) octroyer l'accréditation aux cliniques et aux banques [recommandation 22(2)] ;

c) effectuer des inspections auprès des cliniques et des banques accréditées [recommandation 22(2)] ;

d) modifier, révoquer ou suspendre l'accréditation de toute clinique ou banque qui ne se conforme pas à la loi, aux règlements ou aux exigences de son accréditation [recommandation 22(2)] ;

e) établir un registre central chargé de recueillir les rapports annuels des cliniques et de mettre à la disposition du public les statistiques tirées des rapports ;

f) analyser les taux de succès de la procréatique et d'autres renseignements tirés des rapports annuels des cliniques, et compiler des statistiques ;

g) prendre les mesures nécessaires pour prévenir l'exploitation et la mercantilisation dans le domaine de la procréation médicalement assistée ;

h) promouvoir la recherche et les études dans le domaine de la procréatique, notamment en vue de réduire le taux de grossesse multiple, de mettre au point des techniques reposant sur le cycle normal d'ovulation [recommandation 15] et de déterminer les effets (physiologiques et psychologiques) à long terme des techniques de procréation médicalement assistée sur les enfants qui en sont nés [recommandation 20] ;

i) déterminer, sur la base des données nationales, les problèmes soulevés par la procréation médicalement assistée ;

j) conseiller les autorités publiques en matière de procréation médicalement assistée.

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